

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08788

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <span style="float: right;">18 Days</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;">6</span> d. STREET ADDRESS <b>3617 Glenmore Avenue</b>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT F. ALLERS</b> <span style="float: right;">F. ALLES</span> (Served ROBERT)				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>23</b> Year <b>1961</b>													
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 5, 1894</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>6</b> Days <b>18</b>		<b>IF UNDER 24 HRS.</b> Hours <b>18</b> Min. <b>00</b>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Repairman-Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Refrigerators</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>					
<b>13. FATHER'S NAME</b> <b>Henry Allers</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Louisa Myers</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>						<b>16. SOCIAL SECURITY NO.</b> <b>215-05-4937</b>						<b>17. INFORMATION</b> Address <b>Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ENCEPHALOMALACIA, LEFT CEREBRAL HEMISPHERE</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MYOCARDIAL FIBROSIS</b> DUE TO <b>CORONARY AND GENERALIZED ARTERIOSCLEROSIS</b> <b>Terminal</b> (c) <b>ULCERATED RT. ANKLE DUE TO THROMBOSIS, AORTA</b> <b>Portion RECENT</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>TERMINAL BRONCHOPNEUMONIA -</b>												INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b> <b>UNKNOWN</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>6:30</b> e.m. <b>19</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>Baltimore</b> (County) <b>Maryland</b> (State) <b>Md.</b>																	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 5, 1961</b> to <b>August 23, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 23, 1961</b> , and that death occurred at <b>A.M.</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>SEBASTIAN RUSSO, M.D.</b>												<b>22b. DATE SIGNED</b> <b>8/23/61</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>SEBASTIAN RUSSO, M.D.</b>												<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8-25-61</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>Baltimore</b> (State) <b>Maryland</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>/Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>AUG 28 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hunt</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

Baltimore

Fort Howard

13 Days

Baltimore

Baltimore

3007 Channing Avenue

Veterans Administration Hospital

(Served Robert)

Y. M. C. A.

ALLIED (ARMED)

August 23

June 2, 1950

White

Male

Regiment-Infantry

Infantry

Baltimore, Maryland

Henry Albers

Local House

Clinical Records, V.A. Baltimore 18, Maryland

Fort Howard Division

25-02-1951

WM I

Age

EMERGENCY, LEFT CURRENT RESIDENCE

CHRONIC ASTHMA

CHRONIC ASTHMA

CHRONIC AND GENERALIZED ANGINA PECTORIS

UNSTABLE ANGINA DUE TO CHRONIC, FORT HOWARD DIVISION

CHRONIC ANGINA PECTORIS

August 23, 1951

August 23

1951

Handwritten signature

SEBASTIAN HUBCO, M.D.

V.A. BALTIMORE 18, BALTIMORE, MARYLAND

1951

Baltimore National Cancer Institute

8-22-51

Handwritten

Mr. Cook-Ruffin, Inc. 3009 Baltimore, Md. 12, Md. 12, Md. 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, fill in pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 08789

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home.</u>				d. STREET ADDRESS <u>1120 W. Pratt St.</u>			
3. NAME OF DECEASED (Type or print) First <u>CALVERT</u> Middle <u>ARRINGDALE.</u> Last <u>ARRINGDALE.</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1961.</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1884</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Guard Serv. Balto., Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Arringdale</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Dorritee.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>3416 Elloit St. Balto., Md.</u> <u>Mrs. Ferdinand J. Doyle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Hemiplegic left old</u> DUE TO (c) <u>Hemiplegic left old</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/15/61</u> to <u>8/15/61</u> , that I last saw the deceased alive on <u>8/15/61</u> and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1303 Frederick Rd. Catonsville Md.</u> DATE SIGNED <u>8/15/61</u> ACTUAL SIGNATURE <u>W. E. McGloth</u> PHYSICIAN'S NAME (Type) <u>W. E. McGloth</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-18-61.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>5712 O'Donnell St. Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly J. J. J.</u> ADDRESS <u>901 S. Conkling St. Balto., Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1900

MD-DE 14

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1855		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
1900		NEW YORK		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		DR. J. H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
JAMES H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

John - Jones



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8797

08790

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>3yrlmth26dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>		d. STREET ADDRESS <b>Beacon Light Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>B</b> Last <b>Ashton</b>				4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>73</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>transit operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Ashton</b>				14. MOTHER'S MAIDEN NAME <b>Emily</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 18, 1958</b> , to <b>Aug. 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 18, 1961</b> , and that death occurred at <b>8:14 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachler</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>8-18-61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug 19, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F Gasch's Sons</b> ADDRESS <b>Hyattsville M.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the home of the deceased, the attending physician must complete and sign the certificate. If the death occurs elsewhere, the attending physician must complete and sign the certificate, and the funeral director must complete and sign the certificate. The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the home of the deceased, the attending physician must complete and sign the certificate. If the death occurs elsewhere, the attending physician must complete and sign the certificate, and the funeral director must complete and sign the certificate.

VR A15 (4)  
15M 9/60

08330

08330

(M)

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*William H. Miller*

Aug 17, 1901 - 12 Lincoln Cemetery  
Buried Aug 17, 1901 - 12 Lincoln Cemetery  
108 23 27

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the attending physician and completed by the funeral director. Pages 1 and 2 should be filled with  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8798

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08791

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>X Pikesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7043 Concord Road</b>		d. STREET ADDRESS <b>7043 Concord Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>ATTMAN</b> Last <b></b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Yechel Shapiro</b>		14. MOTHER'S MAIDEN NAME <b>Rachel ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mr. Harry Attman- 7043 Concord Road</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1961</b> to <b>Aug 24, 1961</b> , that (I) (we) lost the deceased alive on <b>Aug 23, 1961</b> , and that death occurred of <b>2:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert J. Himelfarb</b>		22b. DATE SIGNED <b></b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT J. HIMELFARB</b>		22d. ADDRESS <b>3501 ST. Paul ST. - Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Shomre Mishmeres</b>		23d. LOCATION (City, town, or county) (State) <b>Rosedale, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol. Levinson &amp; Bros. Inc.</b>		ADDRESS <b>6010 Reist Road</b>	
25a. REC'D BY REGISTRAR <b>AUG 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Hume</b>	

M

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2730

CERTIFICATE OF BIRTH

Birth Date

Birth Place

Birth Date

Birth Place

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not in the hospital or attending physician, this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: If the deceased is not in the hospital or attending physician, this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8799 CERTIFICATE OF DEATH 08792											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>8yr5mth21dys</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>914 Whitelock Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Betti</u> First Middle Last						4. DATE OF DEATH <u>August 1 19 61</u> Month Day Year					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown Moses Spuer</u>						14. MOTHER'S MAIDEN NAME <u>unknown Helena</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> 422.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 10 18 53</u> to <u>Aug. 1 19 61</u> , that (I) (we) last saw the deceased alive on <u>Aug. 1 19 61</u> , and that death occurred at <u>2:00</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Stella Wachslar</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		8-1-61		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>						22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-2-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Ectaw Place</u>						25a. REC'D BY REGISTRAR DATE <u>AUG 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			



895-10

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14

Robertson

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

FOR SHIPMENT TO: STEPHENS FUNERAL HOME, LUMBERTON, NO. CAROLINA

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8800 CERTIFICATE OF DEATH 08793											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN 1b <b>3 Days</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						
3. NAME OF DECEASED (Type or print) <b>DALCHO C. BAILEY</b>					d. STREET ADDRESS <b>838 N. Chapelgate Lane</b>						
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>						
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>7/23/14</b>						
9. AGE (In years last birthday) <b>47</b> yrs.					10. IF UNDER 1 YEAR Months Days						
11. BIRTHPLACE (County & State, or foreign country) <b>Marietta, North Carolina</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Rufus A. Bailey</b>					14. MOTHER'S MAIDEN NAME <b>Leona Arnette</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>WW II</b>						
17. INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGIC PANCREATITIS</b> DUE TO (b) <b>LAENNEC'S CIRRHOSIS</b> DUE TO (c) <b>581.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Brain Syndrome, Delirium Tremens</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>1 YEAR</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that <b>11</b> (this hospital) attended the deceased from <b>8/15/1961</b> to <b>8/19/1961</b> , that <b>11</b> (we) last saw the deceased alive on <b>8/19/61</b> <b>19</b> and that death occurred at <b>6:40</b> a.m. from the causes and on the date stated above.										22b. DATE SIGNED <b>8/19/61</b>	
22a. SIGNATURE <b>Charles E. Rowan</b> M.D.										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES E. ROWAN, M.D.</b>										22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>										23b. DATE THEREOF <b>8-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Cemetery</b>										23d. LOCATION (City, town or county) (State) <b>Lumberton, North Carolina</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight Inc</b>										25a. REC'D BY REGISTRAR <b>AUG 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Rowan</b>											



RECEIVED - CIVIL RIGHTS DIVISION - DEPT. OF JUSTICE

1

Mr. J. Edgar Hoover, Director

U.S. Department of Justice

600 Maryland Road  
Baltimore 11, MD

Hollister, Secretary

Lansdown, Mr. Tolson

Mr. Tolson, Mr. DeLoach, Mr. Mohr, Mr. Bishop, Mr. Casper, Mr. Callahan, Mr. Conrad, Mr. Felt, Mr. Gale, Mr. Rosen, Mr. Sullivan, Mr. Tavel, Mr. Trotter, Mr. Tele. Room, Mr. Holmes, Miss Gandy

11/12/62

11/12/62

Re: [illegible]

RECEIVED - CIVIL RIGHTS DIVISION

RECEIVED - CIVIL RIGHTS DIVISION

2 DAYS

1 YEAR

Chas. H. [illegible]

John A. [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

Re: [illegible]

00213

0003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not a resident of the State of Maryland, the certificate may be retained by the hospital or attending physician. If the certificate is retained by the hospital or attending physician, it must be filed with the State Department of Health, Bureau of Vital Statistics, within 72 hours after death. TO FUNERAL DIRECTOR: A funeral director's certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8801 CERTIFICATE OF DEATH 08294

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>14 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>OBEDE</b> Middle <b>R.</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 19, 1894</b>	
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b>		11. IF UNDER 24 HRS. Hours <b>66</b> Min. <b>66</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Printing Business</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John T. Baker</b>				14. MOTHER'S MAIDEN NAME <b>Annie L. Appleby</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>213-09-9241</b>			
17. INFORMANT <b>Clinical Records, VAH, Balto. Md.</b>				18. Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OLD MYOCARDIAL INFARCTION</b> <b>420-1</b> <b>MOCK</b> CORONARY THROMBOSIS CIRCUMFLEX ARTERY Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c) <b>CHRONIC OBSTRUCTIVE HYPERTROPHIED EMPHYSEMA. BRONCHOPNEUMONIA, BILATERAL</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC OBSTRUCTIVE HYPERTROPHIED EMPHYSEMA. BRONCHOPNEUMONIA, BILATERAL</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>(x)</b> (this hospital) attended the deceased from <b>July 20</b> , 19 <b>61</b> to <b>August 3</b> , 19 <b>61</b> , that <b>xx</b> (we) last saw the deceased alive on <b>August 3</b> , 19 <b>61</b> , and that death occurred <b>3:20AM</b> from the causes and on the date stated above.				22a. SIGNATURE <b>Sebastian Russo, M.D.</b>			
22b. DATE SIGNED <b>8/3/61</b>				22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>			
22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIVISION</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/7/61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Buck Funeral Home, 5305 Harford Rd. Baltimore, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>				25c. REGISTRAR'S SIGNATURE			

3201

(M)

VETERANS ADMINISTRATION HOSPITAL  
6032 BOSTON STREET  
BOSTON, MASS.  
AUGUST 19, 1961

Male

Printing Business, Baltimore, Maryland

John T. Baker

Clinton, New York, VAN, 1960, 1961  
Clinical records, VAN, 1960, 1961

215-00-5211 Fort Howard, Division

OLD MYOCARDIAL INFARCTION

CONGENITAL HEART DISEASE CIRCULATORY SYSTEM

CHRONIC OBSTRUCTIVE PULMONARY DISEASE, BRONCHITIS, EMPHYSEMA

August 2, 1961  
August 3, 1961  
August 3, 1961

August 3, 1961  
August 3, 1961  
August 3, 1961

August 3, 1961  
August 3, 1961  
August 3, 1961

August 3, 1961  
August 3, 1961  
August 3, 1961



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8802  
08795  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Remove "place of residence" and give name of institution) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Leola</b> Middle <b>-</b> Last <b>Barber</b>				4. DATE OF DEATH Month <b>8</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>? 1917</b>	
9. AGE (In years lost birthday) <b>? 44 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		11. BIRTHPLACE (State or foreign country) <b>St. Marys County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Beale</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Rosewood Records, Owings Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dx (a) Infarction of myocardium due to arterio-sclerotic coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>10 hrs.</b> INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>56</b> , to <b>8/23</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/23</b> 19 <b>61</b> , and that death occurred at <b>6:20 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward J. Mathews</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Edward J. Mathews, M.D.</b>				22d. ADDRESS <b>Rosewood State Training School Owings Mills, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>9-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Annapolis Branch</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Newell</b>				25a. REC'D BY REGISTRAR <b>Pike &amp; Co.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>	

James H. Brown, Jr. & Co.  
9-1-1, 1000 Broadway, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the funeral director's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

8804  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08797

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 5 days</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>c/o Post office</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>MERVIN</b> Last <b>BARNES</b>				4. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>1961</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10.12.12.</b>			
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>JOSEPH BARNES</b>				14. MOTHER'S MAIDEN NAME <b>ROSENIA EDISON</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>----</b>					
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO (c) <b>Far advanced bilateral pulmonary tuberculosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>84 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>7:30</b> to <b>8:00</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8:00</b> , 19 <b>61</b> , and that death occurred at <b>9:25</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>W. Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8.6.1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. Newcomer, M.D. Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Face Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Great Mills, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Finner</b>			

(M)

2806

CERTIFICATE OF DEATH

JOSEPH ALEXANDER

10-12-12

ROSENA E. M.

10-12-12

10-12-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

M

I

MEDICAL CERTIFICATION

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8803

CERTIFICATE OF DEATH

Item 23 Film 6294 8/5/61 mb

08796

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1817 Winans Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT W. BARNETT</b>		4. DATE OF DEATH <b>AUGUST 26 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sykesville, Maryland</b>	
13. FATHER'S NAME <b>Samuel Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Sally Fredericks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-05-4942</b>	
17. INFORMANT <b>WW I</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>33-2X DECK</b> (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>SENILE EMPHYSEMA OF LUNGS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>8/23/1961</b> to <b>8/26/1961</b> , that (we) last saw the deceased alive on <b>8/26/1961</b> , and that death occurred at <b>7:55PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Pemberton MD</b>		22b. DATE SIGNED <b>8/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN W. PEMBERTON, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 30, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard Funeral Home, Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8805

## CERTIFICATE OF DEATH

Reg. Dist. No. 08798

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ivy Hall Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUISA</b> Middle <b>+++</b> Last <b>BEARMAN</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1881</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank Koester</b>				14. MOTHER'S MAIDEN NAME <b>Catherine (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Melvin R. Bearman</b>		Address <b>26 Portship Road Baltimore 22, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.0</b> DUE TO (c) <b>420.0</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>2/21</b> , 19 <b>59</b> , to <b>8/5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>8/5</b> , 19 <b>61</b> , and that death occurred at <b>2:55</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Samuel Stern</b> M.D.				PHYSICIAN'S NAME (Type) <b>SAMUEL STERN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR <b>AUG 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

(M)

(I)

CERTIFICATE OF DEATH

1917

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES MONROE		45		M		W		M		Carpenter	
PLACE OF BIRTH		DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
Maryland		April 1, 1872		April 1, 1917		10:30 AM		Heart Disease		Natural	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
Baltimore, Md.		April 1, 1917		10:30 AM		Heart Disease		Natural		J. H. Smith, M.D.	
PLACE OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		CAUSE OF INTERMENT		MANNER OF INTERMENT		SIGNATURE OF CLERK	
Baltimore, Md.		April 1, 1917		10:30 AM		Heart Disease		Natural		J. H. Smith, M.D.	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08799

8805

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN 1b <u>3</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2827 Harlem Ave</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Shadybrook Nursing Home</u> First <u>Sophia</u> Middle <u>Beehler</u> Last <u>Beehler</u>				<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>15</u> Year <u>1961</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 17, 1873</u>		<b>9. AGE</b> (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto., Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Charles Beehler</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Carrie Bender</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>422.1</u>				<b>17. INFORMANT</b> <u>Warren A. Arnold</u> Address <u>17 E. Saratoga St.</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> (b) <u>arteriosclerotic cardiovascular disease</u> (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>422.1</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>July 13, 1960</u> Hour a.m. <u>19</u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>4116 Edmondson Ave., Balto., Md.</u>			
<b>20f. (City or town)</b> <u>Baltimore</u>				<b>20g. (County)</b> <u>Baltimore</u>				<b>20h. (State)</b> <u>Md.</u>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>July 13, 1960</u> to <u>Aug 15, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 14, 1961</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>George A. Knipp</u>				<b>22b. DATE SIGNED</b> <u>Aug 16 1961</u>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>George A. Knipp, M. D.</u>			
<b>22d. ADDRESS</b> <u>4116 Edmondson Ave., Balto., Md.</u>				<b>22e. REC'D BY REGISTRAR</b> <input checked="" type="checkbox"/> <b>22f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knapp</u>				<b>22g. DATE</b> <u>AUG 24 '61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>8/18/61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lauson Park, Balto., Md.</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore</u>				<b>23e. (State)</b> <u>Md.</u>				<b>23f. (County)</b> <u>Baltimore</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the residence of the deceased, the attending physician must complete and sign the certificate. If the death occurs elsewhere, the attending physician must complete and sign the certificate, and the funeral director must complete and sign the certificate. The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the residence of the deceased, the attending physician must complete and sign the certificate. If the death occurs elsewhere, the attending physician must complete and sign the certificate, and the funeral director must complete and sign the certificate.

VR A15 (4)  
15M 9/60

10720

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The following is a list of the names of the persons who have been  
 named in the report of the Committee on the subject of the  
 proposed amendment to the Constitution of the State of New York.  
 The names are given in the order in which they were named.  
 The names of the persons who have been named in the report of the  
 Committee on the subject of the proposed amendment to the  
 Constitution of the State of New York are given in the order in  
 which they were named. The names of the persons who have been  
 named in the report of the Committee on the subject of the  
 proposed amendment to the Constitution of the State of New York  
 are given in the order in which they were named.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8807

## CERTIFICATE OF DEATH

118800

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> c. LENGTH OF STAY IN 1b <u>25 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7910 Bridge Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale X</u> d. STREET ADDRESS <u>7910 Bridge Ave 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Barbara Marie</u>		First Middle Last <u>Berk</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Aug 4 1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Dec. 29, 1883</u>		<b>9. AGE</b> (In years, last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Henry Cumberland</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Kellner</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <u>Agnes M. Anderson 830 S. East Ave 2nd 24</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Arterio Sclerotic Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5 yrs</u> <u>5 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>June 1961</u> to <u>8/4</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/4</u> , 19 <u>61</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Barbara M. Anderson</u>		<b>22b. DATE SIGNED</b> <u>8/4/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Baumgardner</u> M.D.			
<b>22d. ADDRESS</b> <u>Balto 6 Md</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8-8-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sacred Heart Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Philip E. Crach</u>		<b>24b. ADDRESS</b> <u>1211 Chesaco Ave.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>AUG 8 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kenna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the certificate be signed by the attending physician at the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician at the hospital or attending physician. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, may return it to the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

18801

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE HALL</b> c. LENGTH OF STAY IN 1b <b>72 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bernoudy Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WHITE HALL</b> d. STREET ADDRESS <b>Bernoudy Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOREN A.</b> Middle <b>A.</b> Last <b>BERNOUDY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 21, 1866</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>9</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN R. MILLER</b>		14. MOTHER'S MAIDEN NAME <b>ANN MARY FREDRICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>mazie E. Gillette</b> Address <b>WHITE HALL MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 19, 1961</b> to <b>Aug. 19, 1961</b> , that I last saw the deceased alive on <b>Aug. 19, 1961</b> , and that death occurred at <b>MD.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. M. France</b> M.D.		DATE SIGNED <b>8/19/61</b>	
PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>		ADDRESS (Street, city or town, state) <b>PARKTON, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Aug. 22, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WISBURG CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>White Hall Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jacob Hartenstein</b> ADDRESS <b>New Freedom, Pa.</b>		24a. REC'D BY REGISTRAR <b>AUG 23 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

2020

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b>					c. LENGTH OF STAY IN 1b <b>X</b> d. STREET ADDRESS <b>1303 Pineridge Terrace</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1303 Pineridge Terrace</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>BERNSTEIN</b> Last <b>BERNSTEIN</b>					4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 23, 1901</b>		9. AGE (In years last birthday) <b>60</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <b>David Bernstein</b>					14. MOTHER'S MAIDEN NAME <b>Elizaberh ?</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>217-01-1867</b>					17. INFORMANT Address <b>Mrs. Gertrude Bernstein- 1303 Pineridge Terrace</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Coronary Insufficiency</b> DUE TO (c) <b>Hypertensive Art. C. U. Disease</b>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 58</b> to <b>Aug 4</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>July 29</b> 19 <b>61</b> , and that death occurred at <b>6 A</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>Dr. Bernard J. Cohen</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/4/61</b>							
22c. PHYSICIAN'S NAME (Type) <b>Dr. Bernard Cohen</b>					22d. ADDRESS <b>3501 St Paul Street</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Aug 6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chizuk Amuno</b>			23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>						
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Sol. Levinson &amp; Bros. Inc. 6010 Reist Road</b>					25a. REC'D BY REGISTRAR DATE <b>AUG 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

3803

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH  
STATE OF NEW YORK

(M)

PAUL M. ROSE

1913-1914

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1930



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. The law also requires that the death certificate be retained by the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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(I)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8810											
CERTIFICATE OF DEATH											
08803											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						b. COUNTY Baltimore					
c. LENGTH OF STAY IN 1b 2 Mts. 20 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring State Hospital						d. STREET ADDRESS Box 510 RT. 14 Baltimore 20					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Edna Borchers MARY Borchers						4. DATE OF DEATH 8 26 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 13 - 1886		9. AGE (In Years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Maryland, BALTIMORE			
12. CITIZEN OF WHAT COUNTRY? U.S.											
13. FATHER'S NAME XXXXXXXXX HENRY WEHRMAN						14. MOTHER'S MAIDEN NAME XXXXXXXXX MARY UHL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 212 07 2892 B. XXXXXXXX					
17. INFORMATION MR. HARRY J. BORCHERS RT. 14, BOX 511 BALTO 20						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary insufficiency cause last. DUE TO (c) Coronary and Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH hours ? years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (1) (This hospital) attended the deceased from 6-6 1961 to 8-26 1961, that (I) (we) last saw the deceased alive on 8-26 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE P. Ki-Yun Yip						22b. DATE 8/27/61					
22c. PHYSICIAN'S NAME (Type) P. KI-YUN YIP						22d. ADDRESS SPRING GROVE STATE HOSPITAL, BALTO					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF 8/30/61					
23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY						23d. LOCATION (City, town or county) BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.						25a. RECEIVED BY REGISTRAR AUG 29 61					
25b. REGISTRAR'S SIGNATURE Arthur S. Hume											

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John G. ...  
John G. ...

John G. ...  
John G. ...

John G. ...  
John G. ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 881 STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County BaltimoreVillage or City TowsonRegistration Dist. No. 08804

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME CATHERINE M. BRENNAN

If U. S. Veteran, specify WAR

(a) Residence: No. 4904 ALSON DRIVESt. Zone 29

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F.

## 4. COLOR OR RACE

W.5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  
Single5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofSingle

## 6. DATE OF BIRTH (month, day, and year)

Jan. 24, 1878

## 7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.83

## OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.Ass't Treas.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.Emerson Drug Co.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation

## 12. BIRTHPLACE (city or town)

Balto. Md.

(State or country)

## FATHER

## 13. NAME

Thomas Brennan

## 14. BIRTHPLACE (city or town)

(State or country)

## MOTHER

## 15. MAIDEN NAME

Margaret Mitchell

## 16. BIRTHPLACE (city or town)

(State or country)

## 17. INFORMANT

Mrs. John P. Ryan

(Address)

Cambridge Arms Apt.

## 18. BURIAL, CREMATION, OR REMOVAL

Place

New CathedralDate 8/16/61

19.

## 19. UNDERTAKER

Witzke F.B. 4101 Edmondson Ave.

(Address)

AUG 15 '61Arthur S. Kraus

## 20. FILED

19

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

AUGUST 12, 1961.

(Month)

(Day)

193 61  
(Year)

## 22.

I HEREBY CERTIFY, That I attended deceased from

JUNE 1 1959

, 19

to AUGUST 12, 19 61I last saw her alive on AUGUST 12, 1961; death is saidto have occurred on the date stated above, at 4:40 A.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:CARCINOMIA OF SIGMOID FLEXUREDate of onset  
JUNE 1CHRONIC MYOCARDITIS1959.ARTERIOR SCLEROSIS1959.METASSIS.1960.

Other Contributory Causes of Importance:

153.3Name of operation RESECTION COLONDate JUNE 27 1959What test confirmed diagnosis? MICROSCOPE Was there an autopsy? NO.

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

NO.

(Signed)

Charles P. Cloutier M. D.(Address) 3013 SAINT PAUL STREET

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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8812  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08805

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN lb <b>6 WEEKS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE COUNTY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DIKESVILLE</b> d. STREET ADDRESS <b>MOUNT WILSON LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EMMETT</b> Middle <b>ELMO</b> Last <b>BROOKS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>1961</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 19 1913</b>	9. AGE (In years lost birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months <b>48</b>	IF UNDER 24 HRS. Days <b>3</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>LEONARD BROOKS</b>			14. MOTHER'S MAIDEN NAME <b>NANNY BROOKS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>223-18-9207</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION RIGHT CEREBRAL HEMISPHERE</b> DUE TO <b>CEREBRAL VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 MONTHS</b> DUE TO <b>PULMONARY TUBERCULOSIS ACTIVE</b> (c) <b>1 1/2 YEARS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 48 HOURS</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/19 1961</b> to <b>8/3 1961</b> , that (I) (we) last saw the deceased alive on <b>8/3 1961</b> , and that death occurred at <b>12:30 P.</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>8/3/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D. Superintendent</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Graves Chapel Cemetery</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradley Funeral Home</b>		25a. REC'D BY REGISTRAR <b>AUG 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Stanley, Virginia</b>		



(M)

Baltimore County

Wife of

6 weeks.

Pinkville

Mount Wilson Lane

X

August 3

Brooks

ELMO

Farmington

MALB

WHITE

X

June 19 1913 48

USA

Virginia

Construction

LAUREL

Lenny Brooks

Nanny Brooks

773-18-201

NO

X

6/19 12/12 8/3

8/3

8/3



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8813

## CERTIFICATE OF DEATH

08806

<b>1. PLACE OF DEATH</b> e. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSDOWNE</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>LANSDOWNE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>LANSDOWNE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>121 HAZEL AVE.</u>				d. STREET ADDRESS <u>121 HAZEL AVE.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANK M. BROWN</u>			<b>4. DATE OF DEATH</b> <u>AUG. 29 1961</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/85</u>		9. AGE (In years last birthday) <u>75</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BYO RET.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>FRANK A. BROWN</u>				
14. MOTHER'S MAIDEN NAME <u>DUVAL</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Agnes F. Brown</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinson's Disease</u> <u>422.01</u> DUE TO <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>yes</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
2Df. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/2 1961</u> to <u>8/29 1961</u> , that (I) (we) last saw the deceased alive on <u>8/29 1961</u> , and that death occurred at <u>2A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert J. Levickas</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type or print) <u>Herbert J. Levickas</u>				22d. ADDRESS <u>4436 Washington Blvd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PK.</u>			
23d. LOCATION (City, town or county) <u>BALTO. MD.</u>		23e. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Don 28</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician complete and sign the certificate. The law also requires that the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

30230

3123

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be completed and filed in by the funeral director. The law also requires that the death certificate be completed and filed in by the funeral director. The law also requires that the death certificate be completed and filed in by the funeral director.

VR A15 (4)  
15M 9/60

27

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <u>Baltimore Co</u> MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>																																															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>												c. LENGTH OF STAY IN 1b <u>5 mo.</u>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3905 Durley Lane</u>																																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>												d. STREET ADDRESS <u>Baltimore</u>												a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) <u>Brown, William</u>												4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1961</u>																																															
5. SEX <u>M</u>												6. COLOR OR RACE <u>White</u>												7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>1877</u>												9. AGE (In years) IF UNDER 1 YEAR: Months <u>84</u> Days <u>84</u> Hours <u>84</u> Min. <u>84</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>												10b. KIND OF BUSINESS OR INDUSTRY												11. BIRTHPLACE (County & State, or foreign country) <u>Lith</u>												12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																							
13. FATHER'S NAME <u>Mendel Brown</u>												14. MOTHER'S MAIDEN NAME <u>Benjamin</u>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>												16. SOCIAL SECURITY NO. <u>Pearl Fine - same</u>												17. INFORMANT <u>Unknown</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												General & Cerebral arteriosclerosis												INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>																																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)																							
21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>61</u> , to <u>8/16/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/9</u> 19 <u>61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.												22e. SIGNATURE <u>Arthur S. Kunkin</u>												22b. DATE SIGNED <u>8/17/61</u>																																			
22c. PHYSICIAN'S NAME (Type) <u>Arthur S. Kunkin</u>												22d. ADDRESS <u>2320 Eutaw Place</u>												22a. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>8-17-61</u>												23c. NAME OF CEMETERY OR CREMATORY <u>Shaare Tefeloh</u>												23d. LOCATION (City, town or county) (State) <u>Balto Md</u>																							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>												24b. ADDRESS <u>2100 Eutaw Place</u>												25a. REC'D BY REGISTRAR DATE <u>AUG 18 '61</u>												25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kunkin</u>																							

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8814

Items 6, 8, & 14 Film G293 8/22/61 mh

18807

(M)

(I)

8-17-61

Check from the 2000 Central Place  
8-17-61  
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the 2000 Central Place  
the 2000 Central Place

the 2000 Central Place  
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the 2000 Central Place  
the 2000 Central Place

the 2000 Central Place  
the 2000 Central Place

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08808

8815

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>3828 Tudor Arms Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>Theresa</b> Last <b>Butler</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>18</b> Year <b>61</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/7/1865</b>	
9. AGE (In years last birthday) <b>96</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas Butler</b>		14. MOTHER'S MAIDEN NAME <b>Cordelia Streett</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Admission Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Weakness</b> DUE TO (c) <b>ASCVD</b>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Sept.</b> , 19 <b>60</b> , to <b>Aug.</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Aug. 16</b> , 19 <b>61</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED				
ACTUAL SIGNATURE <b>Robert J. Mahon</b>		M.D.		
PHYSICIAN'S NAME (Type) <b>Robert Mahon, M.D.</b>		<b>602 E. Joppa Road.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>21 Aug. 1961</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pylesville, Harford Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		ADDRESS <b>Towson, Maryland</b>		
24a. REGISTRY REGISTRAR <b>21 61</b>		DATE		
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>				

CERTIFICATE OF DEATH

2017

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1972		Baltimore, MD		Natural		Heart Disease		10/15/2017		10:00 AM		Home		Dr. Smith		John Doe	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
Teacher		High School		Married		Hypertension, Diabetes		10/10/2017		10/10/2017		10/15/2017		10:00 AM		Home		Dr. Smith		John Doe			
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
10/15/2017		10:00 AM		Home		Dr. Smith		John Doe		10/15/2017		10:00 AM		Home		Dr. Smith		John Doe		10/15/2017		10:00 AM	

(M)

(J)

10-10-17 10:00 AM Home Dr. Smith John Doe



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8816

## CERTIFICATE OF DEATH

Reg. Dist. No.

08809

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>HENRY</b> First <b>CARROLL</b> Middle <b>LOU</b> Last		4. DATE OF DEATH <b>8/5/61</b> Month <b>8</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 4, 1875</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		9b. AGE (In years lost birthday) <b>86</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INVESTMENT BANKER BALTIMORE COUNTY</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM S. CARROLL</b>		14. MOTHER'S MAIDEN NAME <b>LOUISA TILGHMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. MARTIN McDONOUGH - PHOENIX, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerosis C. U. Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-1</b> , 19 <b>61</b> , to <b>8-5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>8-1</b> , 19 <b>61</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>York Rd PARKTON MD</b> DATE SIGNED <b>8/5/61</b>			
ACTUAL SIGNATURE <b>C. Herbert Mueller</b> M.D.		PHYSICIAN'S NAME (Type) <b>YORK RD PARKTON MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/7/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>IMMANUEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>GLENCO, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. V. Moore</b> ADDRESS <b>805 N. Calvert St.</b>		24a. REC'D BY REGISTRAR <b>AUG 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

CERTIFICATE OF DEATH

336



DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

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FOR STATE  
HEALTH DEPT.

M

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TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 8817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18810

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1815 William Street</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1815 William Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First <b>JOSEPH</b>		Middle <b>GEORGE</b>		Last <b>CARUSO</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-19-26</b>	
9. AGE (In years last birthday) <b>35</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Aviation Agency</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK</b>		14. MOTHER'S MAIDEN NAME <b>Mary Paulus</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>219-22-8259</b>	
17. INFORMANT <b>Anna Maria Caruso</b>		Address <b>1815 William Rd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> 492.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/3/61</b> Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-7-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Philip E. Crach</b>				ADDRESS <b>1211 Chesaco Ave Baltg.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 8 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

100-40

2812

(M)

Handwritten notes and signatures, including "Charles A. [illegible]" and "100-40".

8818

## CERTIFICATE OF DEATH

Reg. Dist. No.

118811

1. PLACE OF DEATH o. COUNTY <i>Baltimore Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Kingsville</i> b. COUNTY <i>Balto Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Kingsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Johnson</i> Last <i>Chapman</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>13th</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 22, 1873</i>
9. AGE (In year's last birthday) <i>87 yrs.</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>13</i> Hours <i>13</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Kingsville Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Jonathan J. Chapman</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Elizabeth Sauer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war & dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs Charlotte M. Gladen</i>		Address <i>Kingsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>610X Congestive Heart Failure</i> DUE TO (b) <i>Hypertrophy of Prostate G.</i> DUE TO (c) <i>St. Y. Tract Infection</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i> <i>15 yrs.</i> <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Basal Ca. Scalp, Strangulated Femoral Hernia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/16</i> 19 <i>45</i> to <i>8/13</i> 19 <i>61</i> , that I last saw the deceased alive on <i>8/12</i> 19 <i>61</i> , and that death occurred at <i>10:35 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clifford F. Hudson M.D.</i>		DATE SIGNED <i>FORT, MD.</i>	
PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug 15, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St John Episcopal</i>	22d. LOCATION (City, town, or county) (State) <i>Kingsville Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer</i>		24a. REC'D BY REGISTRAR <i>Benson Md</i>	
ADDRESS <i>Benson Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 18812

8819

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NRSg. Home</u>				d. STREET ADDRESS <u>130 S. CULVER ST</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK (FRANCIS)</u> Middle <u>D.</u> Last <u>CITY</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>8</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1876</u>	9. AGE (In years lost birthday) yrs. <u>85</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRG R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>George W. CITY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE REYNOLDS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>MR. JOHN H. CITY</u>				Address <u>4201 1/2 GELSTON DR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 1/2 yrs.</u> <u>5+ yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>August 7</u> , 19 <u>61</u> , to <u>Aug 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 7</u> , 19 <u>61</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6348 FREDERICK RD</u> DATE SIGNED <u>Aug 8, 1961</u>							
ACTUAL SIGNATURE <u>John N. Snyder</u> M.D.				DATE SIGNED <u>Aug 8, 1961</u>			
PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER MD</u>				<u>BALTIMORE 28 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.T. Schwab</u> ADDRESS <u>3512 FREDERICK RD</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 11 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

#29

CERTIFICATE OF DEATH

2232

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF WITNESSES	

## CERTIFICATE OF DEATH

Reg. Dist. No.

08813

8820

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ENSOR Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Claire</u> Middle <u>M.</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1891</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS A. Morton</u>		14. MOTHER'S MAIDEN NAME <u>DERBORAH J. New MAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>078-10-8511</u>	
17. INFORMANT <u>ELIZABETH T. MORTON</u>		Address <u>OAKHURST N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>61</u> , to <u>Aug 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>61</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>PARKTON, MD.</u> DATE SIGNED <u>8/21/61</u> ACTUAL SIGNATURE <u>C. M. France</u> M.D. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/24/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. France</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed by the funeral director, TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ORIGINAL  
RECEIVED  
JAN 11 1911

CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.  
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TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00814

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY in lb <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8200 Pulaski Highway</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Oaklyn</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>118 E. Holly Street (6)</b> d. STREET ADDRESS <b>67X-3</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>HARRY A. COADY</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>8 18 1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sept. 29, 1905</b>
<b>9. AGE</b> (In years last birthday) <b>55 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Philadelphia, Penna.</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Henry Coady</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Lillian Auchenlic</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Mrs. Margaret T. Coady 118 E. Holly Ave. Oaklyn, N. J.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State) <b>Oaklyn, N. J.</b>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>8-19-61</b>			
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b> <b>William V. Lovitt, Jr., M.D.</b>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>8-22-1961</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Locustwood Memorial Park</b> <b>22d. LOCATION (City, town, or country)</b> (State) <b>Earlston, New Jersey</b>	
<b>23. FUNERAL DIRECTOR</b> ADDRESS <b>Lilly &amp; Zeiler Inc., 1901 Eastern Ave.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>AUG 22 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur J. ...</i>	

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1932 MEDICAL EXAMINER'S CERTIFICATE - 117 114

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John Henry  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and fill in the funeral director's name and address. Page 4 should be retained by the funeral director.

VR A15 (4)  
ISM 9/59

8822

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08815

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2653 Purnell Drive</b>		d. STREET ADDRESS <b>2653 Purnell Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Delia I. Cole</b>		<b>4. DATE OF DEATH</b> Month <b>Aug</b> Day <b>13</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb 24, 1876</b>
<b>9. AGE</b> (In years lost birthday) <b>85</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>20</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James Hill</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Murray</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <b>Mrs. Mary Schwarzkopf, 2653 Purnell Drive</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442x</b> IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Hypertensive Cardio-Vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal Disease</b> DUE TO (c) <b>Semility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Aug 13, 1961, that (I) (we) last saw the deceased alive on Aug 13, 1961, and that death occurred at 9 AM, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>M. Paul Beyerly</b>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>M. Paul Beyerly</b>		<b>22d. ADDRESS</b> <b>3083 W. North A Baltimore</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8-16-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>David R. Martin</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Aug 17 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur H. Hall</b>			

1933

CENTRAL BANK OF CANADA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
8823					08816				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Fort Howard			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Baltimore		
c. LENGTH OF STAY IN lb		3 Days			d. STREET ADDRESS		1202 Myrtle Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Veterans Administration Hospital			e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		THOMAS L. COLLINS			4. DATE OF DEATH		AUGUST 18 19 61		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Colored				9/17/88		72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Porter		Railroad		Casanova, Virginia		U.S.A.			
13. FATHER'S NAME		John Mann		14. MOTHER'S MAIDEN NAME		Mary V. Burner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		WW I		226-18-2855		Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		BILATERAL BRONCHO PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH		4 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		GENERALIZED ARTERIOSCLEROSIS		UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		TUBERCULOSIS, RIGHT APEX. CYSTITIS.		19. WAS AUTOPSY PERFORMED?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour e.m. p.m.		Month, Day, Year		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. (City or town)		(County) (State)	
19									
21. I certify that (this hospital) attended the deceased from 8/15/1961, to 8/18/1961, that (we) saw the deceased alive on 8/18/1961, and that death occurred at 2:50 PM, from the causes and on the date stated above.		22a. SIGNATURE		Charles E. Rowan		22b. DATE SIGNED		8/19/61	
22c. PHYSICIAN'S NAME (Type)		Charles E. Rowan, M.D.		22d. ADDRESS		VAH, BALTO. 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial		8-23-61		Baltimore National		Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE		Charles R. Law Funeral Home		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
802 Madison Avenue		Baltimore, Maryland		AUG 21 '61		C. R. Law			

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EXPOSURE

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CONFIDENTIAL

Charles F. Howard, Jr.

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Jacobus de Voragine

# CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>	c. LENGTH OF STAY IN 1b <u>1 YR.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1145 CIRCLE DRIVE</u>	d. STREET ADDRESS <u>1145 CIRCLE DRIVE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>LILLIE</u> First <u>CONNELLY</u> Middle <u>CONNELLY</u> Last	<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>SEPT. 19, 1873</u>	9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>UNKNOWN</u>	14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>HELEN DIERING 1145 CIRCLE DRIVE</u> Address
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accid.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardis</u> DUE TO (c) <u>vascular disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>Aug 18</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 17</u> , 19 <u>61</u> , and that death occurred on <u>30</u> M, from the causes and on the date stated above.		
22a. SIGNATURE <u>Thomas L. Todd</u> M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8/18/61</u>
22c. PHYSICIAN'S NAME (Type) <u>2108 St Paul St.</u>	22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-21-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>
23d. LOCATION (City, town, or county) <u>BALTIMORE</u>	(State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis R. Miller 2105 Frederick Ave.</u>	25a. REC'D BY REGISTRAR <u>AUG 21 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur J. Huns</u>

MARTIN LUTHER KING, JR., APRIL 4, 1968

44



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN 1b <b>97 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>5216 Tramore Avenue</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOSEPH F. CORNECELLI</b>					4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 6, 1902</b>		9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months <b>59</b>		IF UNDER 24 HRS. Days <b>8</b> Hours <b>19</b> Min. <b>61</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					13. FATHER'S NAME <b>Michael Cornecelli</b>					14. MOTHER'S MAIDEN NAME <b>Christine Gentile</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>WW I 269-12-5182</b>					17. INFORMANT Address <b>Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PAPILLARY CARCINOMA OF KIDNEY WITH METASTASES</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation: 1/30/61 Found Tumor (papillary carcinoma) Rt. Kidney. Nephrectomy</b>										INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 3 1961</b> , to <b>August 8 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 8 1961</b> , and that death occurred at <b>10:55 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Thomas F. Crahan</b>					22b. DATE SIGNED <b>8/9/61</b>									
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>					22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>8-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		23d. LOCATION (City, town or county) <b>Dauphin County, Pennsylvania</b>		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE <b>WM COOK BLIGHT INC. 6000 HARFORD RD</b>					25a. REC'D BY REGISTRAR <b>DATE AUG 11 '61</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>BALTO CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NANTICOKE</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>R.F.D. 22X-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1407 HUBNER AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOIS B. COX</b>				4. DATE OF DEATH <b>AUG 1 1961</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>w</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/11/98</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher Wicomico Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEO. F. BLOXOM</b>				14. MOTHER'S MAIDEN NAME <b>LAURA CLAYTON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MARVIN E. COX</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastases</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>11 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>July 29</b> , 1961, to <b>Aug 1</b> , 1961, that (I) (we) last saw the deceased alive on <b>July 21</b> , 1961, and that death occurred at <b>2204</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John A. Nesbitt, Jr.</b>				22b. DATE SIGNED <b>8-1-61</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>	
22d. ADDRESS <b>1118 St Paul St. Baltimore 2, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WICOMICO MEM.</b>		23d. LOCATION (City, town or county) (State) <b>SALISBURY MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HILL-JOHNSON</b>				ADDRESS <b>SALISBURY MD.</b>		25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

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# 1 FOR STATE HEALTH DEPT.

This certificate should be executed within 24 hours after death. If delay is necessary, the delay should be stated in the space provided. Pages 1, 2, and 3 to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## Items 18&20 Film 295 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 8827 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00820

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>12801-4</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore md</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>634 Stoner St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Creek</u> Last <u>Creek</u>		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb - 10 - 48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Creek</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Spriggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u>Jillie Creek</u>	
17. INFORMANT <u>Jillie Creek</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.3</u> DUE TO <u>Falling into gravel pit 30 feet deep, filled with water</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from crane into gravel pit about 30 feet deep, while working at Smuch &amp; Sons Sand &amp; Gravel Company, and drowned</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:00</u> p.m. <u>8-19</u> 19 <u>61</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3210 Hammonds Ferry Road</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Balto.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. H. Smith</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-23-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	22d. LOCATION (City, town, or country) (State) <u>Anne Arundel Co</u>
23. FUNERAL DIRECTOR <u>Choy O Wilson</u>		24a. REC'D BY REGISTRAR <u>1000</u>	
ADDRESS <u>1000</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	
		DATE <u>AUG 30 '61</u>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8828

## CERTIFICATE OF DEATH

118821

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 19</b> d. STREET ADDRESS <b>3014 Wells Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EDGAR R. CROOP</b>			4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1961</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>October 4, 1891</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months <b>69</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Scranton, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Oliver Croop</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Jones</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>213-05-9794</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE SUPPURATIVE PERITONITIS</b> DUE TO (b) <b>PERFORATIONS, GANGRENOUS BOWEL</b> DUE TO (c) <b>METASTATIC ADENOCARCINOMA, PERITONEUM AND LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10:30</b> p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>July 28, 1961 August 1, 1961</b>					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 28, 1961</b> to <b>August 1, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 1, 1961</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M. D.</b>		22b. DATE SIGNED <b>8/1/61</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>Aug. 4, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda, 7922 Wise Avenue, Balto. 22, Md.</b>			
25a. REC'D BY REGISTRAR DATE <b>AUG 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8829

## CERTIFICATE OF DEATH

118822

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		d. STREET ADDRESS <u>4419 Furley Ave.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mr. William Thomas Cullen</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1875</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>86</u> yrs.
13. FATHER'S NAME <u>William T. Cullen, Sr.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>Harry W. Cullen 4417 Furley Ave.</u>	17. INFORMANT <u>Mary Flashey</u> Address
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4-22-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>58</u> , to <u>8/28/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/28/61</u> , 19 <u>61</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thos. E. Roach</u>		22b. DATE SIGNED <u>8/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thos. E. Roach, M.D.</u>		22d. ADDRESS <u>5550 Balto Natl Pike., Balto-28-Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8-31-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>AUG 30 '61</u>	
ADDRESS <u>5305 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

VR A15 (4)  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 8 & 9, telephone call -witzke Fun. Home 9/22/61. cad 18823

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> c. LENGTH OF STAY IN 1b <u>420</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> d. STREET ADDRESS <u>420 Academy Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosa L.</u> Middle <u>Culotta</u> Last <u>Rosa L. Culotta</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1869</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Ret. Seamstress Balto. Clothes Co</u>		11. BIRTH PLACE (County & State, or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Anthony Liberto</u>		14. MOTHER'S MARRIED NAME <u>Frances</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>216-07-6132 - Mrs. Frances Alagna Academy Rd</u>		16. SOCIAL SECURITY NO. <u>420</u>	
17. INFORMANT <u>Frances Alagna Academy Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>anemia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-30-61</u> , 19 <u>61</u> , to <u>8-28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>7-6-61</u> , 19 <u>61</u> , and that death occurred at <u>8-28</u> , 19 <u>61</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry S. Gimbel</u> M.D.		22b. DATE SIGNED <u>8/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY S. GIMBEL M.D.</u>		22d. ADDRESS <u>4605 Edmondson Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 1/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Balto. Md</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Fun. 4101 Edmondson Ave</u>		25. REC'D BY REGISTRAR DATE <u>AUG 31 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. L. Frank</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician. Complete and fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8831

## CERTIFICATE OF DEATH

Item 23 Film G292 8/16/61 mh

08824

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY in lb <b>118 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b> d. STREET ADDRESS <b>1330 N. Carey Street</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>MILTON</b>		First <b>---</b>		Middle <b>DIGGS, JR.</b>		Last <b>August</b>		4. DATE OF DEATH Month <b>9</b> Day <b>19</b> Year <b>61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1915</b>		9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coast Guard Yard</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Milton Diggs</b>				14. MOTHER'S MAIDEN NAME <b>Maude Lee</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes give war or date of service) <b>WW II 217-05-6136</b>				17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RETICULUM CELL SARCOMA WITH METASTASIS TO THE</b> <b>200.0 XXXX LIVER</b> Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c) <b>200.0</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(State) <b>(County)</b>			
21. I certify that (this hospital) attended the deceased from <b>April 13 6:00</b> to <b>August 9 1961</b> , that (s) (we) last saw the deceased alive on <b>August 9 1961</b> , and that death occurred at <b>A</b> M, from the causes and on the date stated above.													
22a. SIGNATURE <b>Thomas F. Crahan</b>				M.D. <b>THOMAS F. CRAHAN, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/9/61</b>					
22c. PHYSICIAN'S NAME (Type or print) <b>THOMAS F. CRAHAN, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/14/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>George G. Kelson</b>				ADDRESS <b>1348 N. Calhoun St.</b>		25a. REC'D BY REGISTRAR <b>AUG 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Channing S. Thomas</b>					

1

Baltimore

Baltimore

Port Howard

118 Days

Baltimore 17

Veterans Administration Hospital

330 N. Carey Street

MINOR

1900, 18.

August

Male

Weight

July 19, 1901

42

Junior

Coast Guard Yard

Baltimore, Maryland

U. S. A.

Wilson 1890

1890 Joe

Technical Records, VAN, Baltimore 18, Maryland

PORT HOWARD DIVISION

217-05-0135

18 11

Yes

RETICULAR CELL GANGLIA WITH RETICULUS TO THE

1890 LIVER

August 9, 01

April 13, 01

August 7, 01

THOMAS F. TRAHAN, M.D.

VAN, BALTIMORE 18, MD., PORT HOWARD DIVISION

Partial

Baltimore National Cem. Baltimore 20, Maryland

1340 N. Calhoun St.

George O. Nelson National Home Baltimore 17, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be used by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

8832

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08825

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES RUSSELL DRISCOLL</b>				4. DATE OF DEATH <b>Aug. 1, 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 23, 1901</b>	
9. AGE (In years last birthday) <b>70</b>		10. AGE (In years last birthday) <b>70</b>		11. AGE (In years last birthday) <b>70</b>		12. AGE (In years last birthday) <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TACK MFG.</b>			
11. BIRTHPLACE (State and foreign country) <b>PA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>DENNIS DRISCOLL</b>				14. MOTHER'S MAIDEN NAME <b>MARY AGNES SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-03-7940</b>			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus. Arteriosclerosis generalized</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7-19</b> 19 <b>61</b> to <b>8-1</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-1</b> 19 <b>61</b> , and that death occurred at <b>2:40 PM</b> from the causes and on the date stated above.				22a. SIGNATURE <b>Wm. Newcomer</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>8-1-1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D. Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>AUG-5-1961</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>SAT. CEDAR HILL Cem.</b>				23d. LOCATION (City, town, or county) (State) <b>BROOKLYN, N.Y.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOWARD EDWARDS</b>				25a. REC'D BY REGISTRAR <b>AUG 3 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, \_\_\_\_\_, Clerk of the County Court, do hereby certify that the foregoing is a true and correct copy of the original of the same as the same appears from the records of the County Court of the County of Dallas, State of Texas.

61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a casket, within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a casket, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>921 Garden Drive</b>						d. STREET ADDRESS <b>1921 Garden Drive (21)</b>							
3. NAME OF DECEASED (Type or print) <b>BUD A DRUMMOND</b>						4. DATE OF DEATH Month <b>Aug</b> Day <b>7</b> Year <b>1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1882</b>		9. AGE (In years last birthday) <b>78</b> Yrs.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>William Drummond</b>						14. MOTHER'S MAIDEN NAME <b>Mary Travis</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>202-16-8124</b>						17. INFORMANT <b>Mrs. Perry (Same as above)</b> Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X Cancer of Lung.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>163X</b> (c) <b>163X</b> DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 5 61</b> to <b>Aug 61</b> , that (I) <b>163X</b> last saw the deceased alive on <b>Aug 5 61</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Robert J. Lyden M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>Aug 8, 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN M.D.</b>						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE THEREOF <b>8-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>			23d. LOCATION (City, town or county) (State) <b>Punxsutawney, Pa.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John B. Connelley</b>						ADDRESS <b>418 Eastern Blvd.</b>		25a. REC'D BY REGISTRAR <b>AUG 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8834

## CERTIFICATE OF DEATH

08827

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <b>89 days</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b> d. STREET ADDRESS <b>1610 Harlem Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILLIAM M. DUNHAM</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>August 9 1961</b> Month Day Year															
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 20, 1888</b> <b>73</b> yrs.		<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Trucking</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Self employed</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Waterbury, Connecticut</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>Robert Dunham</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Charity Burns</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW-1</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>WW-1</b>				<b>17. INFORMATION</b> <b>Clinical Records, 3900 Loch Raven Blvd. Balto 18, Md - FORT HOWARD DIVISION</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA, ACUTE</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>420.0</b> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 MINUTE</b> <b>UNKNOWN</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 12 1961</b> to <b>August 9 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 9 1961</b> , and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i>				<b>22b. DATE</b> <b>8/10/61</b>				<b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. CRAHAN</b>				<b>22d. ADDRESS</b> <b>VAH Balto 18, Md. Fort Howard Division</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8-14-61</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore 28, Maryland</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Samuel W. Sullivan, Jr.</i>				<b>24a. ADDRESS</b> <b>1011 N. Arlington Ave. Baltimore, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>AUG 11 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Hanna</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08828

8835

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Samonia Ave.</b>				d. STREET ADDRESS <b>Samonia Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sadie Schwartz Eckert</b>				4. DATE OF DEATH Month Day Year <b>8-1-61 19</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-4-1884</b>	
9. AGE (In years lost birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Schwartz</b>				14. MOTHER'S MAIDEN NAME <b>Susan Frank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Geo. H. Riley, Sr.</b>				Address <b>above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>C-V. R. disease</b> DUE TO (c) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>PARKTON, Md.</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>8/1/61</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/31</b> 19 <b>61</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. M. France</b>				22b. DATE SIGNED <b>8/2/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>				22d. ADDRESS <b>PARKTON, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessop Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>	
24. BURIAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

Balli-ore

Cooneyville

Seaside Ave.

Johns

female white

housewife

George Johnson

home

12. Geo. A. Riley St.

Boyle

Boyle 0-4-01

Boyle Funeral Service, Townsh. H. No.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8835  
CERTIFICATE OF DEATH  
08829

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>5yrs 4 1/2 mon.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>3703 N. Charles St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>EFF</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 3 1869</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Herbert EFF</u>				14. MOTHER'S MAIDEN NAME <u>Mary —</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mrs. Carl P. Schmidt - 3908 N. Charles St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>—</u> 19 <u>61</u> , to <u>present</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/29</u> 19 <u>61</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest C Brown Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/31/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>				22d. ADDRESS <u>1101 N. Calvert St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Heckner + Sons</u>				ADDRESS <u>Balto. 7, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton A. Thomas</u>							

CERTIFICATE OF DEATH

1938

(M)





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be relayed by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician. It is to be completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8837

08830

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>12 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>18</b> d. STREET ADDRESS <b>762 Exeter Hall Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>DEWEY</b> First <b>DEWEY</b> Middle <b>---</b> Last <b>ESAIAS</b>		4. DATE OF DEATH <b>August 28</b> Month <b>August</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1898</b> yrs. <b>63</b>	
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Morris Run, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard Esaias</b>		14. MOTHER'S MAIDEN NAME <b>Jane Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>579-03-7706</b>	
17. INFORMATION <b>WW II</b>		17. ADDRESS <b>Clinical Records, VAH, Baltimore 18, Md. Ft. Howard</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 16, 1961</b> to <b>August 28, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 28, 1961</b> and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Thomas F. Crahan</b> M.D. 22b. DATE <b>8/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/31/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Hgts. Baltimore 7, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 '61</b> 25b. REGISTRAR'S SIGNATURE <b>William B. Harris</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filled in by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8838  
CERTIFICATE OF DEATH  
08831

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>12 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>734 Edmondson Ave.,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>734 Edmondson Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Winfield</b> Last <b>Etzler</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Etzler</b>		14. MOTHER'S MAIDEN NAME <b>? Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. George D. Etzler 3615 Yolando Rd. Balto. 18,</b>	
17. INFORMANT <b>Md.</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> <b>162X</b> DUE TO <b>carcinoma of lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 mo</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/27 1961</b> to <b>8/24 1961</b> , that (I) (we) last saw the deceased alive on <b>8/24 1961</b> , and that death occurred on <b>8/24 1961</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>James E. Rowe</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>8/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James E. Rowe, M.D.</b>		22d. ADDRESS <b>1011 Frederick Rd. 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-28-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home 608 Main St. Catonsville Md.</b>		25a. REC'D BY REGISTRAR <b>DATE SEP 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>James E. Rowe</b>			

CERTIFICATE OF DEATH

1933

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

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Bellevue

Bellevue

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
M  
I  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8839

08832

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> c. LENGTH OF STAY IN 1b <b>10 YRS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>308 OVERBROOK RD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> d. STREET ADDRESS <b>1308 OVERBROOK RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <b>MARY LOUISE FAIRBANKS</b>		4. DATE OF DEATH <b>AUG. 4 1961</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-14-77</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (State or foreign country) <b>PA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>															
13. FATHER'S NAME <b>WILLIAM H. BRITCHER</b>				14. MOTHER'S MAIDEN NAME <b>LEONARD</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. (If yes, give number or date of service)				17. INFORMANT <b>MRS. MARY EBER, 308 OVERBROOK RD</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 MIN.</b>																											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																											
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>8-4-61</b>															
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>				DEPUTY MEDICAL EXAMINER <b>TIMOTHY BALTIMORE</b>				Address (Street, City, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>8-8-1961</b>				22c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>				22d. LOCATION (City, town, or country) (State) <b>BALTO. MD.</b>															
23. FUNERAL DIRECTOR <b>H-W-JENKINS &amp; SONS Co. 4905 YORK RD</b>				ADDRESS				24a. REC'D BY REGISTRAR <b>AUG 9 '61</b>				24b. REGISTRAR'S SIGNATURE <b>William A. Pillsbury</b>															

THE STATE  
OF NEW YORK

(M)

(S)

10788

2832

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

IN SENATE, JANUARY 10, 1921.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1920.

ALBANY: J. B. LEECH, STATE PRINTER, 1921.

PRICE, 10 CENTS.

FOR SALE BY THE STATE BOOK CONCERN, 100 NASSAU ST., N. Y. C.

THE STATE OF NEW YORK.

OFFICE OF THE ATTORNEY GENERAL.

STATE OF NEW YORK.

OFFICE OF THE ATTORNEY GENERAL.

STATE OF NEW YORK.

OFFICE OF THE ATTORNEY GENERAL.

STATE OF NEW YORK.

OFFICE OF THE ATTORNEY GENERAL.

STATE OF NEW YORK.

OFFICE OF THE ATTORNEY GENERAL.

STATE OF NEW YORK.



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Medical Director. Page 1, 2, and 3 of this certificate should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 18833

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Baltimore, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Baltimore, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4216 Lynhurst Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LAWRENCE J. FERSTERMAN</b>				4. DATE OF DEATH <b>August 30, 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1904</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker-retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Fersterman</b>				14. MOTHER'S MAIDEN NAME <b>Fredericka Kodel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>Mrs. Beatrice Clewis, 1506 Rosewick Ave-6,</b>			
17. INFORMANT <b>Mrs. Beatrice Clewis, 1506 Rosewick Ave-6,</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420-1</b> DUE TO <b>Cerebral Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Jack C. Collins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Jack Collins, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>8-31-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/1/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Evan. Lutheran Cem.</b>		22d. LOCATION (City, town, or country) (State) <b>Stemmers Run, Md.</b>	
23. FUNERAL DIRECTOR <b>Ullrich Funeral Home, 4210 Belair Road.</b>				24a. REC'D BY REGISTRAR <b>SEP 5 '61</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

(FIMOWICZ)

## CERTIFICATE OF DEATH

08834

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY in 1b <b>1mthl1dys</b>		d. STREET ADDRESS <b>1424 W. Pratt Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>S.</b> Last <b>Fim</b>		4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>restraunt worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Sherwood</b>		14. MOTHER'S MAIDEN NAME <b>Laura Meyers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioscl. Cardio Vasc. Disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized, severe</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Amputation to lower third of left thigh due to gangrene of left foot</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 12, 1961</b> to <b>8/2, 1961</b> , that (I) (we) last saw the deceased alive on <b>8/2, 1961</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslor</b> M.D.		22b. DATE SIGNED <b>8/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/5/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Crest</b>		23d. LOCATION (City, town or county) (State) <b>Trucksville, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>K. R. WILLIAMS</b>		25a. REC'D BY REGISTRAR <b>AUG 4 '61</b>	
ADDRESS <b>1, Plymouth, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director.

VR A15 (4)  
15M 9/60



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8842

## CERTIFICATE OF DEATH

Reg. Dist. No.

08835

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>104</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PARADISE NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES E FITZPATRICK SR.</b> First Middle Last				4. DATE OF DEATH <b>Aug 14</b> Month Day Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 24-1884</b> 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MATTHEW J FITZPATRICK</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET TINNAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or years; if unknown, No) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-03-9660</b>		17. INFORMANT <b>ELSIE M. FITZPATRICK BALTIMORE</b> Address <b>818 W 34 St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; Chronic Congestive Heart Failure</b> DUE TO <b>420.0</b> (b) <b>Fail ur 2</b> DUE TO <b>Arteriosclerotic Heart Disease</b> (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8/14/61</b>	
20f. (City or town) (County) (State) <b>8/14/61</b>							
21. I certify that I attended the deceased from <b>8/14/61</b> , 19____, to <b>8/14/61</b> , 19____, that I last saw the deceased alive on <b>8/14/61</b> , 19____, and that death occurred at <b>1010 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Mc Graw</b> M.D.				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28 md</b> DATE SIGNED <b>8/17/61</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Mc Graw</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-18-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank St Seitz</b> ADDRESS <b>814 W 36 St BALTO. MD</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Elaine P. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8843

## CERTIFICATE OF DEATH

08856

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <span style="float: right;">55 days</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 29</b> <span style="float: right;">3 V 0 1 - 4</span> d. STREET ADDRESS <b>4606 Manordene Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <b>HARRY P FORNOFF</b>		<b>4. DATE OF DEATH</b> Last Month Day Year <b>August 6 19 61</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 21, 1898</b>		<b>9. AGE</b> (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Hotels</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William Fornoff</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Haddaway</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW-11</b>				<b>16. SOCIAL SECURITY NO.</b> <b>216-10-4420</b>				<b>17. INFORMANT</b> <b>Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md - FORT HOWARD DIVISION</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b> DUE TO (b) <b>SEVERE MYOCARDIAL FIBROSIS</b> DUE TO (c) <b>SEVERE CORONARY STENOSIS AND SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.														INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>							
<b>1. Chronic obstructive hypertrophic emphysema</b> <b>2. Chronic cholecystitis - cholelithiasis</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>									
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 12, 1961</b> to <b>August 6, 1961</b> that <b>(X)</b> (we) last saw the deceased alive on <b>August 6, 1961</b> , and that death occurred at <b>P.M.</b> from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <b>SEBASTIAN RUSSO, M.D.</b>										<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>8/7/61</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>SEBASTIAN RUSSO, M.D.</b>										<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8-10-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) <b>Baltimore</b> <span style="float: right;">(State) <b>Maryland</b></span>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck &amp; Sons, Inc. 5305 Harford Rd.</b>						<b>ADDRESS</b> <b>Balto. 14, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 9 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or attending physician's office, the certificate may be retained by the hospital or attending physician. If the death occurs elsewhere, the certificate must be completed and signed by the attending physician as completely as possible, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 VR A15 (4)  
15M 9/60

3853

(M)

Bellevue

Left-handed

Bellevue - 25

Veteran Administration Hospital

1000 Lancaster Road

Ward

Room 1

Admission

Life

Ward

Admission 21, 1958

25

Glenn

Bellevue

Bellevue, New York

William J. Russo

Bellevue

Bellevue, New York, 3900 East

11

21-11-1958

Admission 21, 1958 - 25

PHYSICIAN CONSULTATION

PHYSICIAN

SEVERE ACUTE MYOCARDIAL INFARCTION

PHYSICIAN

SEVERE CORONARY ARTERIOSCLEROSIS AND ANGINA

PHYSICIAN

- 1. Chronic obstructive pulmonary disease
- 2. Chronic cholecystitis - cholelithiasis

Admission 21, 1958

Admission 21, 1958

Admission 21, 1958

William J. Russo

Bellevue, N.Y.

Bellevue, N.Y., 3900 East

Bellevue, N.Y.

Bellevue, N.Y.

Bellevue, N.Y.

Bellevue, N.Y.

Bellevue, N.Y., 3900 East

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8844 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>(D. C.)</b> b. COUNTY <b>Prince George's</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Marlyn Avenue Bridge</b>				d. STREET ADDRESS <b>5120 Sargent Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MATHIAS</b> Middle <b>FRANCIS</b> Last <b>FORST</b>				4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 61</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1902</b>		9. AGE (In years last birthday) <b>58/59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Administrator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Forst</b>				14. MOTHER'S MAIDEN NAME <b>?</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WWII</b>				16. SOCIAL SECURITY NO. <b>577-40-5732</b>				17. INFORMANT <b>Winnifred Forst</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>975X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>Unknown 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) <b>Balto.</b>		(County) (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Howard G. Shaub</b>				M.D. <b>Howard G. Shaub, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/4/61</b>	
EXAMINER'S NAME (Type) <b>Howard G. Shaub, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>8/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>S. H. Hines Funeral Home</b>		22d. LOCATION (City, town, or country) <b>Washington, D.C.</b>		(State)	
23. FUNERAL DIRECTOR <b>James E. Bruzdyski</b> <b>James E. Bruzdyski 1407 Eastern Ave.</b>						ADDRESS		24a. REC'D BY REGISTRAR DATE <b>AUG 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is complete. It is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08838

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>12 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>843 Eutaw Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GORDON B. FREY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 7, 1889</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John B. Frey</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Griffith</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>218-18-1254</b>		17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO 332X Conditions, if any, which gave rise to immediate cause (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> (c) <b>UNKNOWN</b> DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <b>July 23, 1961</b> to <b>August 4, 1961</b> that (we) last saw the deceased alive on <b>August 4, 1961</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. H. ROBERTSON, JR. M. D.</b> M.D.			
22b. DATE SIGNED <b>8/4/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>			
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>Aug. 7, 61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			
23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner &amp; Sons, Inc., North &amp; Penna. Aves. Baltimore Md.</b>			
25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinnear</b>			

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Baltimore

Baltimore National

A. S. M.

Baltimore

W. H. Robertson & Sons, Inc. North & Penn. Aves.  
Baltimore, Md.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>60 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3612 Frankford Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER J GIBBONS</b>					4. DATE OF DEATH Month Day Year <b>August 14 19 61</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1891 December 24, 1890</b>		9. AGE (In years last birthday) <b>70 69 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd Jobs</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>											
13. FATHER'S NAME <b>Robert Lee Gibbons</b>					14. MOTHER'S MAIDEN NAME <b>De Maria Blades</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service) <b>Yes WW I</b>					16. SOCIAL SECURITY NO. <b>None</b>						
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>					Address <b>Fort Howard Division</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OLD SUB-ARACHNOID HEMORRHAGE</b> DUE TO (b) <b>FRACTURE OF SKULL</b> TERMINAL BRONCHOPNEUMONIA PYELONEPHRITIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>UNKNOWN</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down steps at home</b>						
20c. TIME OF INJURY Month, Day, Year Hour <b>XX</b> <b>6/13/ 19 61</b> p.m.					20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> <b>Home</b>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore</b>					20f. (City or town) (County) (State) <b>Baltimore Maryland</b>						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/2 8/14/61</b>											
ACTUAL SIGNATURE <b>MELVIN B. DAVIS, M.D.</b> EXAMINER'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-17-61</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>			22d. LOCATION (City, town, or country) (State) <b>Baltimore 28, Maryland</b>		
23. FUNERAL DIRECTOR <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14</b>					24a. REGISTRY REGISTRAR <b>MD. AUG 21 61</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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6/13/61

MELVIN S. DAVIS, M.D.

8-17-61

Dr. Cook-Bishop, Inc., 3009 Bedford St., Baltimore, Md.

Baltimore National Com. Baltimore, Md., Maryland

Wm. S. Davis, M.D.

FRAGMENTS OF EVIDENCE  
FEDERAL BUREAU OF INVESTIGATION  
FBI SAN FRANCISCO DISTRICT

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

Old John  
White  
December 24, 1960

Victims' Identification Hospital  
No. 100  
Baltimore

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician complete and file this certificate with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN TB <b>38 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1</b> d. STREET ADDRESS <b>650 W. Mulberry Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT A. GILLIAM</b>		4. DATE OF DEATH <b>August 13, 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 29, 1913</b>	
9. AGE (In years last birthday) <b>48 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Windsor, North Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Gilliam</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Allen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-01-2414</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>		18. ADDRESS <b>Fort Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CARCINOMA OF ESOPHAGUS</b> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 6, 1961</b> to <b>August 13, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 13, 1961</b> , and that death occurred at <b>10:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sebastian Russo M.D.</b>		22b. DATE SIGNED <b>8/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M. D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-17-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson</b>		25a. REC'D BY REGISTRAR <b>NOV 21 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>		25c. DATE	

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*C. meli*

**Conclusion:**

*Journal of Interpersonal Violence*

L. A. G. U.

19-10-215

bioRxiv preprint doi: <https://doi.org/10.1101/000000>; this version posted January 1, 2016. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
c. LENGTH OF STAY IN 1b <u>5 weeks</u>				d. STREET ADDRESS <u>1334 Poplar Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1334 Poplar Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie L. Golden</u>				4. DATE OF DEATH Month Day Year <u>August 29 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1877</u>	
9. AGE (In years lost birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
13. FATHER'S NAME <u>William Fissie</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. Ammenheuser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>1334 Poplar Ave</u>			
17. INFORMANT Address <u>Mrs. George Corix</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4-2-2-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>8/21 1961</u> to <u>8/29 1961</u> , that (I) (we) last saw the deceased alive on <u>8/29 1961</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert J. Levickas</u> M.D.				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Herbert J. Levickas</u>				22d. ADDRESS <u>5305 East Drive</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery Baltimore Maryland</u>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amelrose, Inc. 1328 Sulphur Sp. Rd.</u>				25a. REC'D BY REGISTRAR <u>SEP 5 '61</u> DATE _____			
				25b. REGISTRAR'S SIGNATURE <u>C. J. S. Hume</u>			

BP

THE STATE OF TEXAS,  
COUNTY OF \_\_\_\_\_  
I, \_\_\_\_\_, Clerk of the Court,  
do hereby certify that \_\_\_\_\_  
of the County of \_\_\_\_\_  
State of Texas, is the owner and  
holder of \_\_\_\_\_  
and that the same is duly  
recorded in the \_\_\_\_\_  
book \_\_\_\_\_, page \_\_\_\_\_,  
of the \_\_\_\_\_  
of the County of \_\_\_\_\_  
State of Texas.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the home of the deceased, the certificate may be retained by the hospital or attending physician. If the death occurs elsewhere, the certificate may be retained by the funeral director. The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the home of the deceased, the certificate may be retained by the hospital or attending physician. If the death occurs elsewhere, the certificate may be retained by the funeral director. The law requires that the death certificate be executed within 24 hours after death. If the death occurs in the hospital or at the home of the deceased, the certificate may be retained by the hospital or attending physician. If the death occurs elsewhere, the certificate may be retained by the funeral director.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8849

18842

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10yr8mth24dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>1000 Bentalou Street</b>		
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Annie</b> Last <b>Goll</b>			4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 61</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1871</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James Lett</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
14. MOTHER'S MAIDEN NAME <b>Annie ?</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>unknown</b>		
16. SOCIAL SECURITY NO. <b>unknown</b>			17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>493X</b> (a), stating the underlying cause last. (c) <b>—</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile brain disease</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that <del>at</del> (this hospital) attended the deceased from <b>Oct. 31</b> <b>1950</b> to <b>Aug. 25</b> , 1961, that <del>at</del> (we) last saw the deceased alive on <b>Aug. 25</b> , 1961, and that death occurred at <b>6:15</b> a.m., from the causes and on the date stated above.					
22a. SIGNATURE <b>Stella Wachslar</b>		M.D. <b>—</b>		22b. DATE SIGNED <b>8-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/28/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Lickner</b> <b>Emmanuel B. Brown</b>		ADDRESS <b>1101 N. Calver St. Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>—</b> DATE <b>AUG 29 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Wm J. Lickner</b> <b>Emmanuel B. Brown</b>

8-2-40

8-2-40

(M)

(I)

James W. [illegible]

James W. [illegible]  
[illegible]  
[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

8850

08843

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite</u>		c. LENGTH OF STAY IN 1b <u>about 8 or 6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Granite</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Paul Ave</u>				d. STREET ADDRESS <u>St. Paul Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Gosnell</u>				4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>19 61</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12, 1910</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Myerhoff Const Co</u>		11. BIRTHPLACE (State or foreign country) <u>Granite</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Eugene E. Gosnell</u>				14. MOTHER'S MAIDEN NAME <u>Agnes L. Greenwalt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOCIAL SECURITY NO. <u>215-18-9985</u>		17. INFORMANT <u>Mrs. Agnes L. Gosnell</u> Address <u>St. Paul Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 1010 Leade <u>  </u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 28, 61</u>			
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 30, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Peters</u> ADDRESS <u>8729 Liberty Rd</u> <u>Randalltown, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for narrative notes.

(V)

(P)

ORIGINAL FILED IN BOW

## CERTIFICATE OF DEATH

Reg. Dist. No. 118844

8851

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tollgate, Owens Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tollgate Rd. Owens Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 Tollgate Rd.</u>		d. STREET ADDRESS <u>201 Tollgate Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary Alice</u> Middle <u>Green</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>19 61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1911</u>
9. AGE (In years last birthday) yrs. <u>49</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leo J. Downey</u>	
14. MOTHER'S MAIDEN NAME <u>Alice E. Harrison</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212249098</u>		INFORMANT Address <u>Mrs Louise Collins same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 20</u> , 19 <u>61</u> , to <u>Aug. 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug. 20</u> , 19 <u>61</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		DATE SIGNED <u>8-21-61</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		ADDRESS (Street, city or town, state) <u>48 Main Street Reisterstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>9-23-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1331

18-11-11  
18-11-11  
18-11-11



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 48845

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>			c. LENGTH OF STAY IN 1b <b>1 WEEK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3605 NORTH POINT BLVD.</b>				d. STREET ADDRESS <b>1008 BAYLIS STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHANNA</b> Middle <b>ELEANOR</b> Last <b>GURN</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> , Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 17, 1886</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>		IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B.V.D. CORP.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK GURN</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE BAGER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212 10 5218</b>		17. INFORMANT Address <b>Mrs Eleanor Cox 3605 North Point Blvd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>H-S-C-V-DISEASE</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> (c) <b>—</b> DUE TO <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/16/61</b>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Aug. 17, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FIRST EVANGELICAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>				24a. REC'D BY REGISTRAR <b>AUG 17 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
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94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

M

QUALITY CONTROL

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 8853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9, Film G-294 9/8/61. cdc.

08846

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balls.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1832 Colmar Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</b> Year <b>1961</b>		5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 19, 1894</b>		9. AGE (In years, less birth day) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b>		IF UNDER 24 HRS. Hours <b>6</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Food Chemical Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William F. Hammel</b>		14. MOTHER'S MAIDEN NAME <b>Mae</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-2793</b>		17. INFORMANT <b>Thelma V. Hammel, 1832 Colmar Rd, Balto. #7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Under Senecula disease</b> (a), stating the underlying cause last. (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Geo S. M. Kieffer</b>		M.D. <b>Geo S. M. Kieffer MD</b>		Address (Street, city, town, or county) <b>1010 Leckham</b>		DATE SIGNED <b>Aug 29 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 1/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemty.</b>		22d. LOCATION (City, town, or country) (State) <b>Balto. Md.</b>			
23. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>AUG 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Witzke F.D.</b>					

MEDICAL CERTIFICATION

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100 IN 100  
100 IN 100

Wiltshire  
Bath  
Bath

1932 October 11

1932

Hospital, Bath, Somerset

William A. Hammett

1932-03-03 Thomas A. Hammett, 1932 October 11, 1932

*Handwritten signature*

*Handwritten notes*

*Handwritten notes*

1932-03-03 Thomas A. Hammett, 1932 October 11, 1932

## CERTIFICATE OF DEATH

Reg. Dist. No. 118847

8854

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VA.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHEARN.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORFOLK</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG Home</u>		d. STREET ADDRESS <u>2959 Verdum Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTIE F. HANGER</u>		4. DATE OF DEATH Month Day Year <u>AUG. 27. 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13, 1880</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>VA.</u>
13. FATHER'S NAME <u>FRANKLIN CALBREATH.</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE HANEY.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>RECORDS</u> Address <u>6811 CAMPFIELD RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>Arterio-sclerotic Heart Disease</u> DUE TO (b) <u>(2)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arterio Sclerosis -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1, 1961</u> to <u>Aug 26, 1961</u> , that I last saw the deceased alive on <u>Aug 25, 1961</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Balto Md</u> DATE SIGNED <u>8-27-61</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers.</u>		<u>4108 Liberty Hts Balto. Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/30/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETH. LU. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>WAYNESBORO. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ubbemann</u> ADDRESS <u>6067 Harford Rd md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '61</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TESTING OF DEATH

2384





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8855											
18848											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>44 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 14</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b> d. STREET ADDRESS <b>4803 Arabia Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>GEORGE A. HARRIS</b>						4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 17, 1889</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wood Finisher</b>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>											
13. FATHER'S NAME <b>Frank Harris</b>						14. MOTHER'S MAIDEN NAME <b>Mary Slick</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>						16. SOCIAL SECURITY NO. <b>215-03-7911</b>					
17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-1/2 HRS.</b> <b>YEARS</b> <b>YEARS</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right CVA with Left Hemiparesis, Old Healed Infarct of Myocardium</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 12, 1961</b> to <b>August 25, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 25, 1961</b> , and that death occurred at <b>P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Merle J. Wampler</b> 22c. PHYSICIAN'S NAME (Type) <b>MERLE J. WAMPLER M.D.</b>						22b. DATE SIGNED <b>8-25-61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH Baltimore 18 Md - Ft Howard Division</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>8/29/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>			
23d. LOCATION (City, town or county) (State) <b>BALTIMORE MARYLAND</b>				25a. REG'D. BY REGISTRAR <b>AUG 29 1961</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J Tickner &amp; Sons Inc</b>						25c. REGISTRAR'S SIGNATURE <b>North &amp; Pennsylvania Baltimore Md (Aves)</b>					

VR A15 (4)  
15M 9/60

1888

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1

Baltimore

Fort Howard

14 Days

Baltimore 14

Washington Hospital

4802 1st St. E. Ave

GEORGE

HAROLD

August 22

White

February 14, 1900

Wood Pines

Baltimore, Maryland

U. S. N.

Frank Harris

May 1900

Civilian Records, Baltimore, Md.  
Fort Howard Division

SEP-03-1911

WR 1

105

RECEIVED

RECEIVED

RECEIVED

RECEIVED

August 23

July 18, 1900

1-23-01

Fort Howard Division

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



(M)

Baltimore

Towson

304 Stage Head Rd.

BRICK

White

Harry Barker

Yes

None

Mrs. Carl E. Schumann

William Craig

Sept. 11, 1993

Aug. 18, 1991

304 Stage Head Rd.

Towson

Baltimore

Baltimore

(1)

Aug. 22, 1991 Millersburg Com

Millersburg, Pennsylvania

in Cook-Towson, Inc. Towson, Maryland

## CERTIFICATE OF DEATH

Reg. Dist. No.

088501

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6513 Lehnert Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sudler</b> Middle <b>R. Hartge</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1911</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>4</b> Days <b>17</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Distributor</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry F. Hartge</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Heath</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.11 213-10-3651</b>	
17. INFORMANT <b>Irene Hartge-6513 Lehnert St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE OF AORTIC ANEURYSM</b> DUE TO <b>451X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>15 MINUTES</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEPTEMBER 15, 1961</b> to <b>AUGUST 17, 1961</b> , that I last saw the deceased alive on <b>AUGUST 15, 1961</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel Blumenfeld</b>		ADDRESS (Street, city or town, state) <b>2104 Gayman Oak Ave. Balto Md</b>	
PHYSICIAN'S NAME (Type) <b>8-17-61</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/21/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REC'D BY REGISTRAR <b>4600 Liberty Heights Ave.</b>	
24b. REGISTRAR'S SIGNATURE <b>AUG 18 '61</b>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8853  
CERTIFICATE OF DEATH  
18851

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3. NO. 1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6826 Lock Raven Blvd.</u>				d. STREET ADDRESS <u>1335 W. Lombard St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillie R.</u> Middle <u>Hartman</u> Last <u></u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/4/83</u>	
9. AGE (in years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Valentine Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mildred Dial 1307 Taylor Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of sigmoid colon</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 7, 1961</u> to <u>August 27, 1961</u> that (I) (we) last saw the deceased alive on <u>August 27, 1961</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Curtis Koller, Jr.</u>				22b. DATE <u>8/29/61</u>		22c. PHYSICIAN'S NAME (Type) <u>E. Curtis Koller, Jr.</u>	
22d. ADDRESS <u>8215 Jeffers Circle</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery Baltimore, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambruse, Inc. 1328 Sulphur Spring Rd.</u>				25a. DEC'D BY REGISTRAR <u>AUG 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1924

IN REPLY TO ORDER

2324

(M)

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 12th inst. in relation to the matter of the estate of the late John A. Smith, deceased, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
[Signature]

**MEDICAL CERTIFICATION**

VR A15 (4)  
15M 9/60

22

2001

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

1940

[illegible]

**RESEARCH DESIGN**

... ..

STANDARD INDEX, N.D.

1997

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINERS: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 8860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08853

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Frederick</b> Last <b>Herrmann</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1889</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>		IF UNDER 1 YEAR Hours <b>-</b> Min. <b>-</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>fireman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fire Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes 1917-19</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pulmonary infarction and thrombosis</b>							
DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b>							
DUE TO (c) <b>Generalized arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bumper frac.; rt. leg from auto accident 7-20-61 -closed reduct. &amp; cast at Fort Howard Hosp. - subsequent gangrene of the right leg</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. struck by automobile on 7-20-61 sustaining bumper frac. right leg</b>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>7-20 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Baltimore, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>8-3-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-7-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL BALTIMORE</b>		22d. LOCATION (City, town, or country) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>Geo. L. Schwab 2101 Fendrich Ave.</b>							
ADDRESS				24a. REC'D BY REGISTRAR <b>AUG 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. S. Hume</b>	

MEDICAL CERTIFICATION

M

3V 01-4

014

3V

2



M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the hospital or attending physician, if the death is reported to the funeral director, page 4 may be retained by the funeral director. This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8861											
8854											
Item 2 Film 6294 9/5/61 ink											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3V01-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4601 Fall Mall Road, Baltimore 15/8 Md.</b> d. STREET ADDRESS <b>3305 Nerak Road</b> <b>4601 Fall Mall Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>LOUIS</b> First <b>HOFFENBERG</b> Middle <b>---</b> Last				4. DATE OF DEATH <b>August</b> Month <b>17</b> Day <b>1961</b> Year							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1890</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clothing Cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>New York, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Barrett Hoffenberg</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Bouch</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I</b>				17. INFORMANT <b>VAH, Baltimore 18, Maryland</b> <b>Clinical Records, Fort Howard Division</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (b) <b>XXXX</b> (a), stating the underlying cause last. (c) <b>CEREBROVASCULAR ACCIDENT</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>UNKNOWN</b> <b>12 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 15, 1961</b> to <b>August 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 17, 1961</b> , and that death occurred at <b>11:06 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>R. H. ROBERTSON, M.D.</b>				22b. DATE SIGNED <b>8/17/61</b>				22c. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/20/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew Cong.</b>		23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Levinson &amp; Bros. Reisterstown Rd. &amp; Pinkney</b>				25a. REC'D BY REGISTRAR <b>AUG 28 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			

1383

M

I

Baltimore

Port Howard

Veterans Administration Hospital

100th

Male

Clothing Cup

Barrett, Robert

Yes No I None

CONJECTIVE HEART FAILURE

ARTERIO-SCLEROTIC HEART DISEASE

CARDIOVASCULAR SYSTEM

XXXX

August 17, 1961

August 17, 1961

H. H. ROBERTSON, M.D.

Internal

Baltimore, Md

301 Eastman & Assoc. Internists, P.C. & Family - AND 2nd St

VAN, DAVIDSON, 13, MD. VI. HOWARD DIVISION

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08855

1. NAME OF DECEASED  
(Type or Print)

8862

MRS. ANNA M. HORN

2. DATE OF DEATH

AUGUST 3, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

MERCY VILLA

BELLONA AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS

(If rural, give location)

1006 E. 20TH. STREET

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

ABOUT 76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10. A USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

MICHAEL GAENG

14. MOTHER'S MAIDEN NAME

GERTRUDE C. SCHILLING

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. MAY A OREM 116 W. UNIVERSITY

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) Arterio sclerotic cardio-  
vascular disease

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

10 years

L CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

22. I certify that (I) (the hospital) attended the deceased from December 10, 1955 to August 3, 1961, that (I) (we) last saw the deceased alive on July 29, 1961, and that in (my) (our) opinion death occurred at 6:25 A.M. from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ M. D.

Eleven East Chase Street

8-4-61

24a. BURIAL, CREMATION,  
REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION

(City, town, or county)

(State)

BURIAL

8/5/61

HOLY REDEEMER

BALTIMORE, MARYLAND

25a. DATE REC'D BY HEALTH DEPT.

25b. NAME OF REGISTRAR

25c. FUNERAL DIRECTOR

ADDRESS

AUG 9 '61

Conroy S. Krause

H.W. MEARS & SON 805 N. CALVERT ST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





35230

35230

1

1





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8864

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Catonsville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Catonsville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6002 Moorehead Road</u>		d. STREET ADDRESS <u>16002 Moorehead Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Louis S. Humphreys</u>		4. DATE OF DEATH Month <u>10</u> Year <u>1961</u> <u>August 27</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1927</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward J. Humphreys</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Schlag</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2 274-24-5009</u>	
17. INFORMANT <u>Mrs. Darlene E. Humphreys</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO <u>hanging himself from rafters</u> Conditions, if any, which gave rise to immediate cause (b) <u>in cellar</u> (c) <u>suicide</u> DUE TO <u>suicide</u> (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bald</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>hanging himself by cloth line from rafters in cellar</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Aug 28 1961</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Catonsville Baltimore Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>GEO S. H. KUEFFER</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO S. H. KUEFFER, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>AUG 30 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records or you may forward it to the funeral director; Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
HISTORY OF ILLNESS		PREVIOUS ILLNESS		SURGICAL HISTORY		MEDICAL HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		VITAL SIGNS		LABORATORY TESTS		X-RAY		AUTOPSY	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		STATE	

(M)

(I)





8238

8238

(M)

Hammond

Hammond

Hammond

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
8866  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08859

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) ✓ a. STATE <i>Maryland</i> b. COUNTY <i>Balto. City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY IN 1b <i>3 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training Sch.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>JACOBS</i> Last <i>JACOBS</i>		4. DATE OF DEATH Month <i>August</i> Day <i>19</i> Year <i>1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White (Indian)</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-17-56</i>
9. AGE (In years lost birthday) <i>5 1/2</i> yrs.		10. IF UNDER 1 YEAR Months <i>+</i> Days <i>+</i> Hours <i>+</i> Min. <i>+</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harvey Jacobs</i>		14. MOTHER'S MAIDEN NAME <i>Arline Chavis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Rosewood Records</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe dehydration - Uremia</i> DUE TO <i>Chronic renal disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>—</i> (b) <i>—</i> (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Subdural hematoma - Microcephaly</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>9-22-1961</i> , to <i>8-19-1961</i> , that (I) (we) last saw the deceased alive on <i>8-19-1961</i> , and that death occurred at <i>4:25</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Harry G. Bucler</i>		22b. DATE SIGNED <i>—</i>	
22c. PHYSICIAN'S NAME (Type) <i>Harry G. Bucler</i>		22d. ADDRESS <i>Rosewood State Training School</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-22-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Bear Swamp</i>		23d. LOCATION (City, town, or county) (State) <i>Penbrook, North Carolina</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lilly &amp; Zeiler Inc., 1901 Eastern Avenue</i>		25a. REC'D BY REGISTRAR <i>—</i> 25b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>AUG 22 '61</i>		DATE <i>AUG 22 '61</i>	

(M)

9883

CERTIFICATE OF DEATH

11-17-53

*[Faint, mostly illegible text follows, likely containing personal details and medical information.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
8867 08860														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>					c. LENGTH OF STAY IN 1b <b>Baltimore 12 (Rogers Forge)</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>512 Murdock Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>GEORGE GARDINER JOYCE</b>					4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1895</b>		9. AGE (In years last birthday) <b>66</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <b>William Joyce</b>					14. MOTHER'S MAIDEN NAME <b>Annie Holt</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No Yes WW I</b>					16. SOCIAL SECURITY NO. <b>216-14-1302</b>					17. INFORMANT <b>Family Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma.</b> 1/2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>5 mo.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>8/2</b> , 19 <b>66</b> to <b>8/26</b> , 19 <b>61</b> that (I) <del>(the)</del> last saw the deceased alive on <b>8/26</b> , 19 <b>61</b> , and that death occurred at <b>CA</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>N.R. Freeman</b>					22b. DATE SIGNED <b>8/28/61</b>		22c. ADDRESS <b>1111 24th St.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 29, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Lutheran Com.</b>		23d. LOCATION (City, town or county) (State) <b>Blenheim, Balto. Co., Md.</b>								
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>					25a. REC'D BY REGISTRAR <b>DATE AUG 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>							

(M)

(I)

Baltimore

Baltimore 12

212 Nantux Road

GEORGE CARDINER JOYCE

White

Merchant-retired

William Joyce

No Yes W I

Maryland

Baltimore 12 (Nantux Forge)

212 Nantux Road

GEORGE CARDINER JOYCE

1876, 1885

Crown Cork & Seal Maryland

Amie Holt

212-14-1302 Family Record

August 26, 61

66

1921

*George Cardiner Joyce*

*W. R. Freeman Jr.*  
*2/26/61*  
*2/26/61*

Bureau Mr. 26, 1961 St. John's Lutheran Ch. Baltimore, Balto. Co., Md.

John Burns' Sons, Towson, Maryland

may be [redacted] by the attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8868

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08861

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>24 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Henry</b> Last <b>Keene, Sr.</b>		4. DATE OF DEATH Month <b>August 4,</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1866</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	11. UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Thomas Henry Keene</b>		14. MOTHER'S M maiden name <b>Eliza Emory Travers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>LECOMPTE FUNERAL SERVICE</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMACIATION</b> <b>191.3</b> DUE TO <b>METASTATIC CARCINOMA RIGHT SUBMANDIBULAR NODE (PRIMARY SITE RT. ALA NASI)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>191.3</b> (c) <b>191.3</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>ABOUT 1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GENERALIZED ARTERIO SCLEROSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>AUG. 1</b> 1961, to <b>AUG. 4</b> 1961, that (I) (we) last saw the deceased alive on <b>AUG. 1</b> 1961, and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>T. C. Siwinski</b>		22b. DATE SIGNED <b>8/4/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thaddeus C. Siwinski, M.D.</b>		22d. ADDRESS <b>206 W. Pennsylvania Avenue, Towson, Md.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Church Creek, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Home, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [redacted] 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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death. [redacted] 4 may be retained by the hospital or attending physician. [redacted] TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

8869

# CERTIFICATE OF DEATH

118862

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Arbutus			
	c. LENGTH OF STAY IN 1b 2yr 14mth 26dys				d. STREET ADDRESS 2017 Hammonds Ferry Road			
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	3. NAME OF DECEASED (Type or print) Matabel		First Middle Last Kelly		4. DATE OF DEATH Month Day Year August 18 19 61			
	5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
	13. FATHER'S NAME Samuel Cooper				14. MOTHER'S MAIDEN NAME Ida Mundy			
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 214-20-9945		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 430.0 DUE TO (b) Sub-acute bacterial endocarditis with Lung, pancreas, spleen abscesses XXXXX (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
	21. I certify that (I) (this hospital) attended the deceased from March 12, 1959, to Aug. 18, 1961, that (I) (we) last saw the deceased alive on Aug. 18, 1961, and that death occurred at 5:05 P.M. from the causes and on the date stated above.	22a. SIGNATURE Stella Wachsler	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8-18-61	22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		
	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/21/61	23c. NAME OF CEMETERY OR CREMATORY London Park Cem	23d. LOCATION (City, town or county) (State) Baltimore Md	24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenney Inc/600 Hollins Ave/MD	ADDRESS 25a. REC'D BY REGISTRAR AUG 22 61	25b. REGISTRAR'S SIGNATURE A. H. S. Frank	

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, D.C.

(1)

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Date of Birth: [illegible]  
7. Sex: [illegible]  
8. Race: [illegible]  
9. Education: [illegible]  
10. Occupation: [illegible]  
11. Marital Status: [illegible]  
12. Number of Children: [illegible]  
13. Date of Arrival: [illegible]  
14. Date of Departure: [illegible]  
15. Date of Interview: [illegible]  
16. Name of Interviewer: [illegible]  
17. Name of Supervisor: [illegible]  
18. Name of Agent: [illegible]  
19. Name of Agent: [illegible]  
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90. Name of Agent: [illegible]  
91. Name of Agent: [illegible]  
92. Name of Agent: [illegible]  
93. Name of Agent: [illegible]  
94. Name of Agent: [illegible]  
95. Name of Agent: [illegible]  
96. Name of Agent: [illegible]  
97. Name of Agent: [illegible]  
98. Name of Agent: [illegible]  
99. Name of Agent: [illegible]  
100. Name of Agent: [illegible]



1884

187

(M)

(I)

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be signed by the attending physician or the funeral director. The law also requires that the death certificate be signed by the attending physician or the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8872 CERTIFICATE OF DEATH 08865

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3822 Victoria Avenue</u>		d. STREET ADDRESS <u>3822 Victoria Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Myrtle Irene Klawnberg</u>		4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thornton</u>		14. MOTHER'S MAIDEN NAME <u>Grace Simering</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mr. William Klawnberg</u>	
17. INFORMANT <u>same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Arteriosclerotic heart disease</u> (c) <u>Hypertensive Arteriosclerotic heart disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 31</u> , 19 <u>61</u> , to <u>Aug. 31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John J. Darrell</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. DARRELL</u>		22d. ADDRESS <u>9017 LIBERTY RD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/5/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '61</u>	
ADDRESS <u>5305 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

3773



Leonard J. Wick 250 Hartford Road 210 Sept 21  
Serial 11/101 Baltimore Conn. Distribution 116



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8873

## CERTIFICATE OF DEATH

Reg. Dist. No. 08866

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES (TINGER)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>KOEHLER</u> Last <u>KOEHLER</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/88</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>MRS. D. RUTKOWSKI 743 S. CONKLING ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia.</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Renal Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>10 3/4</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-30-</u> , 19 <u>61</u> , to <u>8-3-</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-3-</u> , 19 <u>61</u> , and that death occurred at <u>1:50</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Road</u> DATE SIGNED <u>8-3-61</u>	
PHYSICIAN'S NAME (Type) <u>William K. Gallagher, M.D.</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF/ <u>AUG. 7, 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.W. Hoffmann</u>		ADDRESS <u>3218 HUDSON ST.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

2873

58

NAME OF DECEASED CHARLES WHITE		DATE OF BIRTH 1913		PLACE OF BIRTH Maryland	
SEX Male		AGE 28		MARRIAGE Married	
OCCUPATION Unknown		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1941		PLACE OF DEATH Home		CITY Baltimore	
COUNTY Baltimore		STATE Maryland		COUNTRY United States	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	

8874

CERTIFICATE OF DEATH

Reg. Dist. No. 18867

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8219 BELAIR RD</b>		d. STREET ADDRESS <b>1 8219 BELAIR RD</b>	
3. NAME OF DECEASED (Type or print) <b>Krank</b> First <b>J</b> Middle <b>Kurek</b> Last		4. DATE OF DEATH <b>August 16, 1961</b> 19	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 4 1896</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>ANCHOR POST</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS KUREK</b>		14. MOTHER'S MAIDEN NAME <b>ELEANOR STUPZINSKI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARY KUREK 8219 BELAIR RD</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Failure</b> DUE TO (c) <b>Coronary Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 21</b> , 1959, to <b>Aug. 16</b> , 1961, that I last saw the deceased alive on <b>Aug. 3</b> , 1961, and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>August 17 '61</b>			
ACTUAL SIGNATURE <b>Theodore E. Evans</b> M.D.		PHYSICIAN'S NAME (Type) <b>Theodore E. Evans, M.D. 9660 Belair Rd. Balto. 6, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-19-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM</b>	22d. LOCATION (City, town, or county) (State) <b>DUNDALK AVE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M WEBER &amp; SONS INC. 4015 CHESTER ST</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08868

1. NAME OF DECEASED  
(Type or Print)

8875

ERNEST C. LAMBERT

2. DATE OF DEATH

AUG 7, 1961

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If NOT in hospital or institution, give STREET  
ADDRESS OR LOCATION)

1213 FAIRFIELD AVE

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

MARYLAND

Baltimore

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE CO - Mt. Washington

D. STREET ADDRESS

(If rural, give location)

1213 FAIRFIELD AVE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

9-7-08

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

9

10. A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

WELDER

10b. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOSEPH LAM

14. MOTHER'S MAIDEN NAME

MARY HOLLAR

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

NO

(If yes, give war or dates of service)

NONE

16. SOCIAL  
SECURITY NO.

216-07-4585

17. INFORMANT

CHARLES C. BRADFORD

ADDRESS

1213 FAIRFIELD AVE

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐

NO ☐

22. I certify that (I) (this hospital) attended the deceased from Aug 7 1961 to Aug 7 1961, that (I) (we) last saw the deceased alive on Aug 2 1961, and that in (my) (our) opinion death occurred at 4037 Falls Rd. m., from the causes and on the date stated above.

23a. SIGNATURE

Edward H. Glassman

23b. ADDRESS

4037 Falls Rd.

23c. DATE SIGNED

8/7/61

24a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

24b. DATE

8-9-61

24c. NAME OF CEMETERY OR CREMATORY

JEFFERSONS CEMETERY

24d. LOCATION

(City, town, or county)

BALTIMORE CO, MD

(State)

25a. DATE REC'D BY HEALTH DEPT.

AUG 9 1961

25b. NAME OF REGISTRAR

Heather M. Kraus

25c. FUNERAL DIRECTOR

Austin E. Donovan

3818 ROLAND AVE

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8876

08869

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FULLERTON</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4201 FULLERTON AVE.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FULLERTON</b> d. STREET ADDRESS <b>4201 FULLERTON AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>IE</b> Last <b>LESSAHL</b>				4. DATE OF DEATH Month <b>8</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/30/1894</b>	
9. AGE (In years lost birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MECHANIC.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK LESSAHL</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH DOMER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-32-8087</b>		17. INFORMANT <b>MARTHA LESSAHL 4201 FULLERTON AVE</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>Bronchogenic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostatic obstruction; Myocardial Degenerative Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 18, 1961</b> , to <b>Aug 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 18, 1961</b> , and that death occurred at <b>1 p. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John C. Hyle</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-28-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>		22d. ADDRESS <b>7527 Belair Rd Balto 6</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/28/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO CO MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road #6</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8877

CERTIFICATE OF DEATH

08870

Item 2 Film G293 8/25/61 mh

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Md</b> b. COUNTY <b>Baltimore Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville/ Solomons Island</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forrest Haven Nursing Home</b>		d. STREET ADDRESS <b>1315 Ingleside Ave/</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY E. LEATHERING</b> First Middle Last		4. DATE OF DEATH <b>Aug. 14, 1961</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1889</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>24</b>	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>XXXXX U. S. A.</b>		13. FATHER'S NAME <b>John H. O'Bery</b>	
14. MOTHER'S MAIDEN NAME <b>Lulie Clocker</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Nursing Home Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1 A.S.P.V.D. - myocardial infarction</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1961</b> to <b>Aug 12, 1961</b> that (I) (we) last saw the deceased alive on <b>Aug 1, 1961</b> , and that death occurred at <b>12 M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Frederic F. Haulon</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>8/15/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/16/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Calvert County, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>A.A.Harkness &amp; Son, Mutual, Calvert Co., Md.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>AUG 18 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>

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THE UNIVERSITY OF CHICAGO

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, complete and fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8878 Item 24 Film G295 9/14/61 iwk											
09941											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>2 Days</b>			
2. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				3. NAME OF DECEASED (Type or print) <b>CHARLES C. G. LEONARD</b>				4. DATE OF DEATH <b>August 24 19 61</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Mason- Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Caroline Co., Maryland</b>			
13. FATHER'S NAME <b>Charles H. Leonard</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Poole</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>SAW 214-07-7207</b>				17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 22b. DATE SIGNED <b>8/25/61</b>								INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>			
22a. SIGNATURE <b>Thomas F. Crahan</b> THOMAS F. CRAHAN, M.D.				22b. DATE <b>8/25/61</b>				22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/28/61</b>				23c. NAME OF CEMETERY <b>Dorchester Memorial Park</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Home, High Street, Cambridge, Md.</b>				25a. REGISTERAR <b>SEP 11 1961</b>				25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>			
25c. NAME OF CEMETERY <b>Dorchester Memorial Park</b>				25d. LOCATION (City, town or county) <b>Cambridge</b>				25e. STATE <b>Maryland</b>			

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Veterans Administration Hospital

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2879

08871

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE (#6)</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE (#6)</b>		d. STREET ADDRESS <b>1321 Spring Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>NONE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS FRANKLIN LEWIS</b>				4. DATE OF DEATH Month <b>8</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/1881</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hamphshire W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM LEWIS</b>			14. MOTHER'S MAIDEN NAME <b>AMANDA BROWN.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>OSCAR LOWERY</b> Address <b>1321 Spring Ave</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b> <b>5 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 20 1961</b> to <b>Aug 20 1961</b> that (I) (we) last saw the deceased alive on <b>Aug 20 1961</b> and that death occurred on <b>Aug 20 1961</b> at <b>3 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm J. Tichenor &amp; Sons</b> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/20/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Wm J. Tichenor &amp; Sons</b>			22d. ADDRESS <b>Balto 6 Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/23/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT BETHEL</b>		23d. LOCATION (City, town or county) (State) <b>THREE CHURCHES W. VA.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tichenor &amp; Sons</b>			ADDRESS <b>North Penn Ave Balto. 17, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 22 '61</b>		
			25b. REGISTRAR'S SIGNATURE <b>Arthur J. Francis</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8880

## CERTIFICATE OF DEATH

08872

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto. Co.</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>24 Locust St.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>24 Locust St.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>24 Locust St.</u>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARRY G. LOCHENAUER</u>				<b>4. DATE OF DEATH</b> <u>Aug. 31 1961</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 8, 1878</u>									
<b>9. AGE</b> (In years, last birthday) <u>83</u> yrs. <table border="1"> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.					<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
Months	Days	Hours	Min.												
<b>13. FATHER'S NAME</b> <u>Henry Lochenauer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Holly Myers</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-07-2388</u>		<b>17. INFORMANT</b> <u>Agnes L. Morton</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> (b) <u>Arterio-sclerotic Cardio Vascular Disease</u> (c) <u>Age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma Bronchial</u>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8/14</u> , 19 <u>61</u> , to <u>8/31</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Cliff Ratliff, Sr.</u>				<b>22b. ADDRESS</b> <u>460 S EDMONDSON AVE</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>CLIFF RATLIFE, SR.</u>				<b>22d. ADDRESS</b> <u>460 S EDMONDSON AVE</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>9/2/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Balto. Co. Md.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Don</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>SEP 5 '61</u>											
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hennes</u>				<b>25c. DATE</b> <u>SEP 5 '61</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

39107-51 35.20

# 1 FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
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MEDICAL CERTIFICATION

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 8881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08873

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4940 Hazelwood Ave.</b>				d. STREET ADDRESS <b>4940 Hazelwood Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>CLARENCE G. LUKEN</b>				4. DATE OF DEATH <b>August 26 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30-1882</b>	9. AGE (in years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August William Luken</b>				14. MOTHER'S MAIDEN NAME <b>EMMA GRINDALL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. A. Wm. Luken - 4932 Hazelwood</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head.</b>							
976 X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>XXXX</b> <b>8/26 19 61</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Fullerton Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				DATE SIGNED <b>8/27/61</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-30-61</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem</b>				22d. LOCATION (City, town, or country) (State) <b>BALTO Md</b>			
23. FUNERAL DIRECTOR <b>Leonard J. Luck</b>				24a. REC'D BY REGISTRAR <b>29 61</b>			
ADDRESS <b>5305 Hayford A.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

(M)

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Californian

1810 Madison Ave.

1110 Madison Ave.

DECEMBER 10, 1910

THURSDAY

AUGUST 10

1910

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August 10, 1910

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1810 Madison Ave.

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TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MEDICAL CERTIFICATION

tem 18-21 film 293 8-30-61 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8882 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08876											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY in 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bridge #3, Warren Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3204 Second Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>DORIS</b> Middle <b>MARGARET</b> Last <b>MACAULEY</b>						4. DATE OF DEATH Month <b>Found August 2</b> Day <b>1961</b> Year <b>61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 10, 1925</b>		9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary Johns Hopkins Hosp.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George H. Macauley Sr.</b>						14. MOTHER'S MAIDEN NAME <b>Emma D. Dietz</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>						16. SOCIAL SECURITY NO. <b>(If yes give number or date of service)</b>		17. INFORMANT Address <b>Mr. George H. Macauley, Jr.</b> <b>same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>975 X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned</b>							
20c. TIME OF INJURY Month, Day, Year <b>2</b> <del>XX</del> <b>7/30</b> <b>1961</b> Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) <b>Baltimore</b>		(County) _____ (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/2/61</b> ACTUAL SIGNATURE <b>Howard G. Shaub</b> EXAMINER'S NAME (Type) <b>Howard G. Shaub, M.D.</b> Address (Street, city, town, or county) _____											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>				22d. LOCATION (City, town, or country) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck 5305 Harford Road #14</b>						24a. REC'D BY REGISTRAR DATE <b>AUG 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			

5223



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, filing the word "pending" in pencil in item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> c. LENGTH OF STAY IN 1b <b>9 YRS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>510 WINDWOOD RD</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 12</b> d. STREET ADDRESS <b>1570 WINDWOOD RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>LEROY JOSEPH MARTIN</b>				4. DATE OF DEATH <b>AUG 3 1961</b>							
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-24-96</b>		9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLOTHING DESIGNER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Company</b>				11. BIRTHPLACE (State or foreign country) <b>M.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Martin</b>				14. MOTHER'S MAIDEN NAME <b>Rose Martin</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WWI</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>MRS. MARY ULTMANN'S 6155 PARKWAY DRIVE, BALTO 12</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>4-20-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 hr. 15 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Timonivum</b> Address (Street, city, town, or county) <b>2060 YORK RD BALTO</b>				<b>8-3-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/7/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Star OF The Sea</b>				22d. LOCATION (City, town, or County) (State) <b>Golden Hill, Md.</b>			
23. FUNERAL DIRECTOR <b>Le Compte Funeral Service, Cambridge, Md.</b>						ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	

M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8884

08875

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Arbutus)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Baltimore (Arbutus)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5116 Shelbourne Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>B.</b> Last <b>Maxwell, Sr.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21,</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1890</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rome Theatrical Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Maxwell</b>				14. MOTHER'S MAIDEN NAME <b>Annie Barlow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>XXXX</b>		17. INFORMANT <b>Bertha V. Maxwell</b> Address <b>5116 Shelbourne Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> 151 X DUE TO <b>Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <i>James Frederick</i> 22c. PHYSICIAN'S NAME (Type) <b>James Frederick, M. D.</b>				22b. DATE SIGNED 22d. ADDRESS <b>Francis Avenue</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue #29</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 22 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8885

08877

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN Yr <b>65 years</b>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown,</b>		d. STREET ADDRESS <b>Cockeys Mill Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cockeys Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Ellen McCauley</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1895</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Reisterstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harris Uhler</b>		14. MOTHER'S MAIDEN NAME <b>Emma Gore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Marion Zimmerman, Finksburg, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis, intra abdominal</b> <b>199X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7-30-51</b> , 19....., to <b>8-9-61</b> , 19....., that (I) (we) last saw the deceased alive on <b>8-8-61</b> , 19....., and that death occurred at <b>3 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Caples</b>		22b. DATE SIGNED <b>8-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		22d. ADDRESS <b>6 Hanover Rd., Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 12, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Reisterstown Methodist</b>		23d. LOCATION (City, town or county) (State) <b>Reisterstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry James Eckhardt</b>		25a. REC'D BY REGISTRAR <b>AUG 11 '61</b>	
ADDRESS <b>Owings Mills, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
38885  
CERTIFICATE OF DEATH  
08878

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Catherine</b> Last <b>Mc Clain</b>		4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>61</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Mc Clain</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Noel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Admission Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>ADAMS - STOKES</b> DUE TO (c) <b>ASCVD.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept.</b> 19 <b>60</b> to <b>8/17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> 19 <b>61</b> , and that death occurred at <b>7:41</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>D. Mahan M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>D. Mahan M.D.</b>		22d. ADDRESS <b>602 E. Joppa Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>8/18-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank J. Seely</b>		24. ADDRESS <b>814 W 36th St</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Huns</b>	

10-23-38

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

2882

(M)

(J)



12  
11

8887

## CERTIFICATE OF DEATH

Reg. Dist. No.

08879

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2421 Wythe Ave.</u>		d. STREET ADDRESS <u>2421 Wythe Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Blair Medlin</u>		4. DATE OF DEATH Month Day Year <u>August 7 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10. 1909</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John I. Medlin</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Jane Bees</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>465-12-6269</u>	
17. INFORMANT <u>Mrs. Julia Medlin, 2421 Wythe Ave. Balto. 19</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's Sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>60</u> , to <u>August 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>August 7</u> , 19 <u>61</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>John V. Conway</u> M.D. <u>8-8-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 9, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten signature: *Wm. L. G. ...*

John V. Campbell



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and correctly filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
8888  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08880

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3433 Philips Drive</b>		d. STREET ADDRESS <b>3433 Philips Drive 1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Harry Louis Minch</b> First Middle Last		4. DATE OF DEATH <b>August 20, 1961</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 25, 1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>deceased - unknown</b>		14. MOTHER'S MAIDEN NAME <b>deceased - unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Theresa Minch-- Same</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>527-2</b> IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/6</b> 19 <b>61</b> to <b>8/20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/20</b> 19 <b>61</b> , and that death occurred on <b>6</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Leonard R. [Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chizuk Amuno Cong.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SOL LEVINSON &amp; BROS INC 6010 Reist. Rd. Balto Md</b>		25a. REC'D BY REGISTRAR <b>AUG 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. [Signature]</b>			

(M)

(I)

John Colman

John Colman

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8889

08881

(M)

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lisbon, Maryland</b>	
c. LENGTH OF STAY in lb <b>19yr5mth7dys</b>		d. STREET ADDRESS <b>13X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruby</b> Middle <b>Morgan</b> Last <b>Morgan</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Levi Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Anna Gaver</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiac failure</b> (c) <b>Arteriosclerotic cardiovascular disease</b> DUE TO cause last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>March 3, 19 42</b> to <b>Aug. 15, 19 61</b> that <del>it</del> (we) last saw the deceased alive on <b>Aug. 15, 19 61</b> , and that death occurred at <b>12:45 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>8-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<b>Burial</b>		<b>Aug. 18, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		23d. LOCATION (City, town or county) (State) <b>Frederick Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Waltz Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 18 '61</b>	
ADDRESS <b>Sykesville Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and the funeral director sign the certificate. The law also requires that the attending physician and the funeral director sign the certificate. The law also requires that the attending physician and the funeral director sign the certificate.

VR A15 (4)  
15M 9/60

10230

8239

(M)

(1)

10230

8239

10230

8239

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 18882

8890

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>225 Overbrook Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Maeller</u> Last <u>Maeller</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1889</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Christian Mueller</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Mareck</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MR William GRAHAM</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>463</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Phlebotomy of Rt. Suprarenal V.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 30, 1961</u> to <u>Aug 10, 1961</u> , that I last saw the deceased alive on <u>Aug 9, 1961</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Carr, Jr.</u>		ADDRESS (Street, city or town, state) <u>6201 York Rd Baltimore, Md.</u> DATE SIGNED <u>8/14/61</u>					
PHYSICIAN'S NAME (Type) <u>Dr. Charles Carr, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8-14-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>AUG 14 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CENTRAL AIR OF DEATH





may be signed by the attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8891  
08883  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2306 N. Rolling Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W.</b> Last <b>Mumford</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-25-1887</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		10. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sup. &amp; Starter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Md. Race Track</b>		11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U/S.A.</b>							
13. FATHER'S NAME <b>Sidney J. Mumford</b>				14. MOTHER'S MAIDEN NAME <b>Sophia E. McKee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-03-6397</b>		17. INFORMANT <b>Mrs. N. Lee Mumford</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis - Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Hypertensive C.V. Disease</b> (c) <b>Arteriosclerotic Heart Disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>24 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>2/4/5</b> 19 <b>52</b> to <b>8/21</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/19</b> 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edwin L. Pierpont</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>				22d. ADDRESS <b>8204 LIBERTY Rd - BALTO. 7, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Young &amp; Dyers</b>				25a. REC'D BY REGISTRAR <b>8728 Liberty Road Randallstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hanna</b>	

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February 7

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State Department  
Washington, D.C.  
February 7, 1957

State Department  
Washington, D.C.  
February 7, 1957

## CERTIFICATE OF DEATH

Reg. Dist. No. 08884

8892

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>113 GLENMORE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN F. MURPHY</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 20 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 18, 1899</b>
9. AGE (In years lost birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL J. MURPHY</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE PEIFFER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>W.W.I</b>		16. SOCIAL SECURITY NO. <b>216-01-7216</b>	
17. INFORMANT Address <b>MRS. MABEL E. MURPHY 113 GLENMORE AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Complete heart block.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Disease + chronic myocardial infarction</b> (c) <b>Atherosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> to <b>Aug 20, 1961</b> , that I last saw the deceased alive on <b>August 19, 1961</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Nelson McRay</b>		ADDRESS (Street, city or town, state) <b>6014 Edmondson Ave Balto 29, Md 8/24/61</b>	
PHYSICIAN'S NAME (Type) <b>G. Truman Schwab</b>		DATE SIGNED <b>AUG 24 '61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG 24, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. TRUMAN SCHWAB</b>		24a. REC'D BY REGISTRAR <b>Arthur L. Hanna</b>	
ADDRESS <b>3512 FREDERICK AVE</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8893

## CERTIFICATE OF DEATH

08885

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>				c. LENGTH OF STAY IN 1b <b>18</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armcast Nursing Home 812 Regester Avenue</b>				d. STREET ADDRESS <b>Warrington Apts., 3908 North Charles St</b>			
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>J.</b> Last <b>Oliver</b>				4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1882</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick D. Hall</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Mumma</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Fred. E. Hall, 121 Gothard Road, Lutherville, Md</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular hemorrhage</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1956</b> to <b>Aug 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 17, 1961</b> , and that death occurred at <b>7:50 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Alfred G. Ossman, Jr.</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-20-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred G. Ossman, Jr. M.D.</b>				22d. ADDRESS <b>216 East University Parkway, Zone 18</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>				25a. REC'D BY REGISTRAR <b>AUG 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Director of  
Bureau of  
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Johnston, Inc., 100 York Ave., New York



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8894

08886

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY P.O.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Catonsville</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>1137 Cherrydel Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>JOHNNYCAKE RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN L. OPEL</b>				4. DATE OF DEATH <b>AUG 1 1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-2-1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Harmon-Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>August Opel</b>				14. MOTHER'S MARRIED NAME <b>Elizabeth Klein</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>4-4-1</b>			
17. INFORMANT <b>Mrs. Mildred Smith - White Marsh - Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> <b>450.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>metastatic carcinoma</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1wk</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/11/61</b> , 19... to <b>8/1/61</b> , 19...; that (I) (we) last saw the deceased alive on <b>7/11/61</b> , 19...; and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Milton Schlennoff</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Balto Md</b>	
22c. PHYSICIAN'S NAME (Type) <b>Milton Schlennoff</b>				22d. ADDRESS <b>6410 Windsor Mill Rd</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. M. M. - Son</b>				ADDRESS <b>28</b>		25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "MAY", "JUNE", and "1952" are faintly visible.]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

08887

8895

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium Balt City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 Belfast Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Julia</u> Middle <u>Agatha</u> Last <u>O'Sullivan</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7th</u> Year <u>19 61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Reardon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Riordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address <u>Mrs. Catherine Eckert 28 Belfast Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardio Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1956</u> to <u>Aug 7th 1961</u> , that I last saw the deceased alive on <u>Aug. 7th 1961</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M. K. Quinn</u> M.D. <u>1927 YORK RD, TIMONIUH, 8/8/61</u>			
ACTUAL SIGNATURE <u>M. KEVIN QUINN M.D.</u>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

(M)

1. Name of Deceased: John A. Smith

2. Sex: Male

3. Age: 65

4. Date of Birth: Jan 15, 1890

5. Date of Death: Dec 10, 1955

6. Place of Birth: Baltimore, Md.

7. Usual Residence: 1234 Main St., Baltimore, Md.

8. Cause of Death: Myocardial Infarction

9. Duration of Illness: 2 weeks

10. Place of Death: Home

11. Signature of Physician: Dr. J. B. Jones

12. Signature of Registrar: W. H. Brown

13. Date of Registration: Dec 15, 1955

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>8895</div> <div> <div> <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> </div> <div> <div>Baltimore</div> <div>MARYLAND</div> </div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>b. COUNTY</div> </div> <div> <div>Maryland</div> <div>Baltimore</div> </div> </div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>Mr. Peter</div> <div>Phillips</div> </div> <div> <div>4. DATE OF DEATH</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>August</div> <div>23rd</div> <div>19</div> <div>61</div> </div> </div>											
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5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

male

white

WIDOWED

DIVORCED

May 5, 1889

72 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired Cook

Greece

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

John Phillips

Diane ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes give war or dates of service)

17. INFORMANT

Address

(Yes, no, or unknown)

051-74-0141

Mrs. Bessie Phillips

same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary Occlusion

(b)

Generalized Advanced Atherosclerosis

(c)

Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

Sound.

undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES

NO

20a. EXTERNAL CAUSE WAS PRIMARY

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

p.m.

19

While at work

Not While at work

21. I certify that I took charge of the remains described above, held an Autopsy

Inspection

Inquiry

and in my opinion death resulted from:

Natural causes

Accident

Suicide

Homicide

Undetermined manner

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JOHN C. Hyle

JOHN C. Hyle

M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

8-24-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

Burial

8/26/61

Greek Orthodox Cem.

Baltimore, Maryland

23. FUNERAL DIRECTOR

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Leonard J. Ruck

5305 Harford Road #14

DATE AUG 25 '61

Arthur S. Hanna

M



100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
8897														
Item 23 Film G294 9/5/61 mh														
18889														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN lb <b>73 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					d. STREET ADDRESS <b>1923 Brunt Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ROBERT A. POWELL</b>					4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>August 6, 1899</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Morgue attendant</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Pathology</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Mount Washington, Maryland</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					13. FATHER'S NAME <b>William Powell</b>					14. MOTHER'S MAIDEN NAME <b>Ella Dutton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>					16. SOCIAL SECURITY NO. <b>212-18-0865</b>					17. INFORMATION <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>Fort Howard, Division</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG WITH METASTASIS TO LUMBAR VERTEBRAE, 4-5, LIVER, PERICARDIUM, HILAR LYMPH NODES</b> 162.1 XXXX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XXXX BILATERAL PYLONEPHRITIS AND HYDRONEPHROSIS</b> (b) <b>UNKNOWN</b> (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					(County)					(State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 16, 1961, to August 28, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 28, 1961</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Sebastian Russo</b>					22b. DATE SIGNED <b>8/29/61</b>									
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>					22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>Sept. 1, 1961</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>				
23d. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b>														
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ludlow H. Carroll</b>					25a. REC'D BY REGISTRAR <b>SEP 1 '61</b>					25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>				

M

8007

Information

Information

Very Heavy

Very Heavy

Very Heavy

Veterans Administration Hospital

Veterans Administration Hospital

Home

Home

Home

Home

Home

Home

Home

William Jones

William Jones

William Jones

Home

Home

Home

BROOKHURST CARTRIDGE, 1ST BUNG WITH METABOLIC  
AND TO LUNGS VENTRAL, 4-5 LUNG, METABOLIC, BUNG  
WITH NOSE

WOOD BILATERAL PYROSTOMY AND HYPOSTOMY

WOOD

August 23

August 23

*John H. Carroll*

STATIONER, R.D.

Washington National Cemetery, Baltimore 20, Maryland

John H. Carroll, 810 Madison Ave., Balto 2, Md.

SEP 1 1961

SEP 1 1961

VAN, BALTO 15 10, ST. LOUIS DIVISION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2898

## CERTIFICATE OF DEATH

Reg. Dist. No.

08890

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>		c. LENGTH OF STAY IN 1b <b>25 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9525 Belair Rd.</b>		d. STREET ADDRESS <b>9529 Belair Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edith</b> First <b>Jeann</b> Middle <b>Preble</b> Last		4. DATE OF DEATH Month <b>Aug.</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-9-1897</b>
9. AGE (In years, lost birthday) <b>63</b> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Henry Wolfes</b>		14. MOTHER'S MAIDEN NAME <b>Francis Ellen Bodine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. Douglas Preble</b>		Address <b>9525 Belair Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephrosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes</b> DUE TO (c) <b>Arterio sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b> <b>2 yr +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov.</b> 19 <b>60</b> , to <b>Aug.</b> 19 <b>61</b> , that I last saw the deceased alive on <b>Aug 1</b> 19 <b>61</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William A. Tyson</b> M.D.		ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>Aug. 1, 1961</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lessie J. Howard</b>		ADDRESS <b>7401 Belair Rd. Balt. Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

CERTIFICATE OF DEATH

1932

DATE OF DEATH

1932

1932

1932

1932

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Usual residence</p>		<p>7. Date of death</p>		<p>8. Time of death</p>	
<p>9. Cause of death</p>		<p>10. Manner of death</p>		<p>11. Signature of physician</p>		<p>12. Signature of registrar</p>	
<p>13. Signature of informant</p>		<p>14. Signature of witness</p>		<p>15. Signature of registrar</p>		<p>16. Signature of registrar</p>	
<p>17. Signature of registrar</p>		<p>18. Signature of registrar</p>		<p>19. Signature of registrar</p>		<p>20. Signature of registrar</p>	
<p>21. Signature of registrar</p>		<p>22. Signature of registrar</p>		<p>23. Signature of registrar</p>		<p>24. Signature of registrar</p>	
<p>25. Signature of registrar</p>		<p>26. Signature of registrar</p>		<p>27. Signature of registrar</p>		<p>28. Signature of registrar</p>	
<p>29. Signature of registrar</p>		<p>30. Signature of registrar</p>		<p>31. Signature of registrar</p>		<p>32. Signature of registrar</p>	
<p>33. Signature of registrar</p>		<p>34. Signature of registrar</p>		<p>35. Signature of registrar</p>		<p>36. Signature of registrar</p>	
<p>37. Signature of registrar</p>		<p>38. Signature of registrar</p>		<p>39. Signature of registrar</p>		<p>40. Signature of registrar</p>	
<p>41. Signature of registrar</p>		<p>42. Signature of registrar</p>		<p>43. Signature of registrar</p>		<p>44. Signature of registrar</p>	
<p>45. Signature of registrar</p>		<p>46. Signature of registrar</p>		<p>47. Signature of registrar</p>		<p>48. Signature of registrar</p>	
<p>49. Signature of registrar</p>		<p>50. Signature of registrar</p>		<p>51. Signature of registrar</p>		<p>52. Signature of registrar</p>	
<p>53. Signature of registrar</p>		<p>54. Signature of registrar</p>		<p>55. Signature of registrar</p>		<p>56. Signature of registrar</p>	
<p>57. Signature of registrar</p>		<p>58. Signature of registrar</p>		<p>59. Signature of registrar</p>		<p>60. Signature of registrar</p>	
<p>61. Signature of registrar</p>		<p>62. Signature of registrar</p>		<p>63. Signature of registrar</p>		<p>64. Signature of registrar</p>	
<p>65. Signature of registrar</p>		<p>66. Signature of registrar</p>		<p>67. Signature of registrar</p>		<p>68. Signature of registrar</p>	
<p>69. Signature of registrar</p>		<p>70. Signature of registrar</p>		<p>71. Signature of registrar</p>		<p>72. Signature of registrar</p>	
<p>73. Signature of registrar</p>		<p>74. Signature of registrar</p>		<p>75. Signature of registrar</p>		<p>76. Signature of registrar</p>	
<p>77. Signature of registrar</p>		<p>78. Signature of registrar</p>		<p>79. Signature of registrar</p>		<p>80. Signature of registrar</p>	
<p>81. Signature of registrar</p>		<p>82. Signature of registrar</p>		<p>83. Signature of registrar</p>		<p>84. Signature of registrar</p>	
<p>85. Signature of registrar</p>		<p>86. Signature of registrar</p>		<p>87. Signature of registrar</p>		<p>88. Signature of registrar</p>	
<p>89. Signature of registrar</p>		<p>90. Signature of registrar</p>		<p>91. Signature of registrar</p>		<p>92. Signature of registrar</p>	
<p>93. Signature of registrar</p>		<p>94. Signature of registrar</p>		<p>95. Signature of registrar</p>		<p>96. Signature of registrar</p>	
<p>97. Signature of registrar</p>		<p>98. Signature of registrar</p>		<p>99. Signature of registrar</p>		<p>100. Signature of registrar</p>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8900  
CERTIFICATE OF DEATH  
08892

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edman Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>20 Shady Nook Avenue</b>		d. STREET ADDRESS <b>20 Shady Nook Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen C. Pruitt (Also Helen B. Pruitt)</b> Middle <b></b> Last <b></b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1, 1913</b>
9. AGE (In years lost birthday) <b>47 yrs.</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Ward's</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>John E. Bothmer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Steinwedel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-09-5256</b>	
17. INFORMANT <b>Wilbur R. Pruitt</b>		Address <b>20 Shady Nook Ave. #28</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Returned dissecting aneurysm of abdominal aorta</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerosis</b> DUE TO (c) <b>Diabetes mellitus, Pyelitis acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 31</b> 19 <b>61</b> , to <b>Aug 7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug 2</b> 19 <b>61</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. E. Calas</b>		22b. DATE SIGNED <b>8/7/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. A. E. Calas, M. D</b>		22d. ADDRESS <b>4 N. Fulton Ave., Balto. M.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 9 '61</b>	
ADDRESS <b>4107 Wilkens Avenue #29</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. *here attached*

1014

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
8901		Items 2 & 7 Film 0292		8/11/61		08893					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>4mth23dys</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick Md. Pasadena</b> d. STREET ADDRESS <b>Galvest Co. Nursing Home</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Albert</b>			First <b>Albert</b> Middle <b></b> Last <b>Quist</b>		4. DATE OF DEATH <b>August 1 1961</b>		Month <b>August</b> Day <b>1</b> Year <b>1961</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1876</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sweden</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>Sweden</b>			
13. FATHER'S NAME <b>unknown</b>					14. MOTHER'S MAIDEN NAME <b>unknown</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>					16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b> DUE TO <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b> (County) <b></b> (State) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>March 8 1961</b> to <b>Aug. 1 1961</b> that (I) (we) last saw the deceased alive on <b>Aug. 1 1961</b> , and that death occurred at <b>1:25 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Stella Wachslar</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>8-1-61</b>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>					22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b></b>			23b. DATE THEREOF <b></b>		23c. NAME OF CEMETERY OR CREMATORY <b></b>		23d. LOCATION (City, town or county) <b></b> (State) <b></b>				
24 FUNERAL DIRECTOR'S SIGNATURE <b></b>					ADDRESS <b></b>		25a. REC'D BY REGISTRAR <b></b>		25b. REGISTRAR'S SIGNATURE <b></b>		
					DATE <b>AUG 7 '61</b>		<b>Charles E. Thomas</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8902

08894

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kelly Ave.		d. STREET ADDRESS Kelley Ave.	
3. NAME OF DECEASED (Type or print) Sophia Jane Randall		4. DATE OF DEATH August 27, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1862
9. AGE (In years last birthday) 98 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Tracey	
14. MOTHER'S MAIDEN NAME Annie E. Morfett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sophia J. Kelley Lutherville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X MYOCARDIOTIC CHRONIC DECOMPENSATION DUE TO (b) HYPERTENSION DUE TO (c) GENERAL ARTERIOSCLEROSIS CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1-30, to 8-27-61, that (I) last saw the deceased alive on 8-27-61, and that death occurred at 3P, from the causes and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James G. Saffell MD.		22d. ADDRESS Reisterstown, Md 8-28-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 30, 61	
23c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		23d. LOCATION (City, town or county) Reisterstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		25. ADDRESS Reisterstown, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE SEP 1 '61		Arthur L. Kraus	

MEDICAL CERTIFICATION

M

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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. For this certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8903											
CERTIFICATE OF DEATH											
08895											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2414 Madison Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILLIAM H. REASON</b>						4. DATE OF DEATH Month Day Year <b>August 30 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 17, 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bell Man - unemployed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Reason</b>						14. MOTHER'S MAIDEN NAME <b>Carolina MN: Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>						16. SOCIAL SECURITY NO. <b>WW I</b>					
17. INFORMANT <b>Clinical Records, VAH, Fort Howard Division</b>						Address <b>Baltimore 18, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> DUE TO <b>MYOCARDIAL INFARCTION AND INTRAMURAL THROMBOSIS</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY INFARCTION, RIGHT LUNG</b> (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (a) (this hospital) attended the deceased from <b>August 27, 19 61</b> to <b>August 30, 19 61</b> that (b) (we) last saw the deceased alive on <b>August 30, 19 61</b> and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>SEBASTIAN RUSSO, M.D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>			22b. DATE SIGNED <b>8/30/61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>9-2-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS <b>Charles R. Law, 802 Madison Ave., Baltimore, Md.</b>						25a. REC'D BY REGISTRAR <b>SEP 1 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>		

1903

Bellevue

Fort Howard

8 days

Veterans Administration Hospital

1414 Madison Avenue

William

H.

Henson

August

30

62

Regio

December 17, 1907

Hotel - unemployed

Philadelphia, Pennsylvania

John Henson

Wt 1

Yes

Charles H. Henson  
Clinical Records, V.A. Fort Howard Division  
Bellevue 18, Maryland

PURCHASE SECTION  
HYPODERMIC INJECTION AND INTRAVENOUS THERAPY  
PURCHASE SECTION, LIGHT TUNG

1 DAY  
WILSON  
1 DAY

August 30

August 30

*John W. H.*

BRADLEY, H.B.

V.A. BELLEVUE 18, MD., FT. HOWARD DIVISION

Bellevue

Bellevue National Cemetery

Division 1, New, 605 Madison Ave., Baltimore, Md.

August 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and is complete. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8904

08896

<b>1. PLACE OF DEATH</b> a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN 1b MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Maryland c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 18 3V01-4 d. STREET ADDRESS Cambridge Arms Apartments Charles and 34th Streets e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Lee M. Reely <b>4. DATE OF DEATH</b> Month Day Year August 30 1961		<b>5. SEX</b> male <b>6. COLOR OR RACE</b> white <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> June 12, 1886 <b>9. AGE</b> (In years last birthday) 75 yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Supervisor <b>11. BIRTHPLACE</b> (County & State, or foreign country) Dayton, Howard Co, Md <b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> George Reely <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) yes <b>16. SOCIAL SECURITY NO.</b> W.W.I <b>17. INFORMANT</b> Mrs. Caroline Reely, Cambridge Arms Apt. 18 <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 yr.	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19 <b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify</b> that (I) (this hospital) attended the deceased from 8-24-1961, to 8-30-1961, that (I) (we) last saw the deceased alive on 8-29-1961, and that death occurred at 7:54 PM, from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> Wilmer K. Gallager M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) Wilmer K. Gallager M.D.		<b>22b. DATE SIGNED</b> 8-31-61 <b>22d. ADDRESS</b> 6209 Frederick Ave Baltimore 28, Md.	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) BURIAL <b>23b. DATE THEREOF</b> 9-1-61 <b>23c. NAME OF CEMETERY OR CREMATORY</b> Baltimore National <b>23d. LOCATION</b> (City, town or county) (State) Baltimore		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Wm. Cook, Inc., 1217 St. Paul Street, Zone 2 <b>25a. REC'D BY REGISTRAR</b> DATE SEP 1 '61 <b>25b. REGISTRAR'S SIGNATURE</b> Arthur L. Kraus	

1000

(1)

(1)



1. PLACE OF DEATH o. COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsvill</u>		c. LENGTH OF STAY IN 1b <u>16 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsvill</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>523 Academy Rd</u>		d. STREET ADDRESS <u>523 Academy Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Reid</u> Last <u>Reid</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>3,</u> Year <u>1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1921</u>	9. AGE (In years last birthday) <u>39</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Sec'y Equitable Trust Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>		11. BIRTHPLACE (State or foreign country) <u>W. S. A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>W. S. A</u>		13. FATHER'S NAME <u>John Reid</u>		14. MOTHER'S MAIDEN NAME <u>Ilean Muir</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Elmora Reid (Wife)</u>		17. INFORMANT <u>Elmora Reid (Wife)</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420</u> IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>8/13/61</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Neural Calculus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> 19 <u>61</u> , to <u>8/13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/13</u> 19 <u>61</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Thos E Roche</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Thos E Roche</u>	
22d. ADDRESS <u>5550 Belton Road, Baltimore</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL-CREATION-REMOVAL (Specify)	23b. DATE THEREOF <u>Aug 7/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City, town, or county)	(State) <u>Balto. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter F. W. 4101 Edmondson Ave</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8905

08898

Item 14 Film G292

8/16/61

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Franklintown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5331 Dogwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary T. Reneker</b>		4. DATE OF DEATH <b>Aug. 7, 19 61</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>William Key</b>	
11. BIRTHPLACE (State or foreign country) <b>Ma.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Carey</b>		14. MOTHER'S MAIDEN NAME <b>Angeline Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-30-3649A</b>	
17. INFORMANT <b>Mrs Lillian Efford, Box 168 A., Fairview Beach, Pasadena P.O. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO <b>Carcinomatosis of Brain long time</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary Carcinoma of Colon</b> DUE TO (c) <b>1 1/2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/10, 1961</b> to <b>8/7, 1961</b> , that (I) (we) last saw the deceased alive on <b>8/5, 1961</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Max J. Miller, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Max J. Miller, M. D.</b>		22d. ADDRESS <b>1047 Ingleside Ave, Balto 28, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/9/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D.4101 Edmondson Ave, Balto.29, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

2008

CENTRAL INTELLIGENCE AGENCY

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# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 9/60

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08899

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyde - rural</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Overlea - rural</b>			
c. LENGTH OF STAY in 1b <b>Never</b>				d. STREET ADDRESS <b>105 Walnut Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bottom Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SAMUEL JESSE RHONE</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21, 1911</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jessie Rhone</b>				14. MOTHER'S MAIDEN NAME <b>Adline Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>205-03-7289</b>			
17. INFORMANT <b>Holcomb Funeral Home., Benton, Pa.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide and alcohol intoxication</b> 973.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Inhaled auto engine fumes and drank whisky</b>			
20c. TIME OF INJURY Month, Day, Year <b>5:00 a.m. Aug. 25 61</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>road</b>				20f. (City or town) (County) (State) <b>rural-Hyde Baltimore MD.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county) <b>8/26/61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Waller Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Jackson Township, Pa.</b>	
23. FUNERAL DIRECTOR <b>Wm. Cook Inc., 1217 St. Paul St. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 29 '61</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Francis</b>			

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Baltimore

Boyle - 1910

Section 11

Boyle

Overline - 1910

108 Walnut Ave.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the attending physician and completed by the funeral director. After it is completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8908

## CERTIFICATE OF DEATH

Reg. Dist. No.

08900

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge Catonsville</u>		c. LENGTH OF STAY IN 1b <u>13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Roberts Ave. (Catonsville Md.)</u>		d. STREET ADDRESS <u>1600 Montgomery Rd.</u> <u>3 Roberts Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Moses Thomas Richardson</u>		4. DATE OF DEATH Month Day Year <u>Aug 19 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>19 61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O (Mt. Clair) Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Stephens (Howard Co.) U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Seawood Richardson-5500 Race Rd.</u>	
17. INFORMANT <u>Mr. Seawood Richardson-5500 Race Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio-sclerosis</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 Days.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12th, 1961</u> , to <u>Aug. 19th, 1961</u> , that I last saw the deceased alive on <u>Aug. 19th, 1961</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Winters Lane Catonsville 28. Md.</u> DATE SIGNED <u>8/19/61</u>			
ACTUAL SIGNATURE <u>C.F. Maloney</u>		M.D. <u>C.F. Maloney, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>		Catonsville 28. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/ 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter-3035 W. North Ave</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>Aug 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

CERTIFICATE OF DEATH

1908

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

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SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8909  
CERTIFICATE OF DEATH  
08901

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY in 1b <u>Reisterstown</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glen Falls Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>Glen Falls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>George</u> <u>Clarence</u> <u>Rimbe</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>August</u> <u>25</u> , <u>19</u> <u>61</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 21, 1876</u>
<b>9. AGE</b> (In years last birthday) <u>85</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Nunton M. Rimbe</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>217-01-7026</u>	
<b>17. INFORMANT</b> <u>Mr. Raymond Rimbe</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Thrombosis</u> DUE TO (b) <u>Decompensating</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Yes</u> INTERVAL BETWEEN ONSET AND DEATH <u>44 hrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>3</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
<b>20f. (City or town)</b> <u>Reisterstown</u> <b>(County)</b> <u>Md.</u> <b>(State)</b> <u>Md.</u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8-23-1961</u> <b>to</b> <u>8-25-1961</u> <b>that (I) last saw the deceased alive on</b> <u>8-23-1961</u> <b>and that death occurred at</b> <u>3:30</u> <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>James B. Saffell</u>		<b>22b. DATE SIGNED</b> <u>8-26-61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>James B. Saffell</u>		<b>22d. ADDRESS</b> <u>Reisterstown</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Aug. 28, 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Gilead Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Baltimore Co.</u> <b>(State)</b> <u>Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Eline &amp; Sons</u>		<b>25a. REC'D BY REGISTRAR</b> <u>SEP 1 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Richard L. Thomas</u>			

BYLAND STATE DEPT

2008

(M)

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "BYLAND STATE DEPT" and "2008" are visible.]*



(C)



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8910

## CERTIFICATE OF DEATH

08902

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1313 Westellen Rd.</u>				d. STREET ADDRESS <u>1313 Westellen Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Rinehart</u>				4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>19 61</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-1887</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Brewer</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Gildenfenny</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Helen M. Christ</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio Vascular renal disease.</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> <u>June 1958</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>Aug 22 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 22 1961</u> , and that death occurred at <u>7A.M.</u> from the causes and on the date stated above.							
22e. SIGNATURE <u>Harold H. Burns</u> M.D.				22b. DATE SIGNED <u>8/25/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Harold H. Burns.</u>				22d. ADDRESS <u>8106 Harford Rd. #</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8-28-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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June 28 1938

July 2 41

8100 H. B. 1938

Harold H. Burns

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Harold H. Burns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8911

08903

M

I

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY in 1b <b>15 MONTHS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3501-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MASONIC HOME</b>			d. STREET ADDRESS <b>5218 BIDDISON LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CLAIRE PRICE ROBINSON</b>			4. DATE OF DEATH Month <b>AUG</b> Day <b>8</b> Year <b>1961</b>		
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1875</b>	9. AGE (in years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JAMES H. PRICE</b>			14. MOTHER'S MAIDEN NAME <b>MARY ZIMMERMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Frank L. Smith Jr. - Cockeysville, Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO <b>15 months</b> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-12</b> 19 <b>61</b> to <b>8-7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-7</b> 19 <b>61</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.					
22e. SIGNATURE <b>Walter T. Kees</b>			22d. ADDRESS <b>COCKEYSVILLE, MD</b>		22b. DATE SIGNED <b>8-8-61</b>
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-10-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8912

08904

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b># 2 Locust Drive #20</b>			
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Anna</b> Last <b>Sacks</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1874</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>27</b> Days <b>24</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Rush</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. William H. Sacks #2 Locust Grove Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory failure</b> 4-2-2-2 DUE TO <b>Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardio-vascular disease.</b> DUE TO (c) <b>Heart failure, chronic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>27 days</b> <b>survival</b> <b>flakes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1961</b> to <b>August 23, 1961</b> , that (I) <del>was</del> saw the deceased alive on <b>August 23, 1961</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Eugene C. Baumann</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-26-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>EUGENE C. BAUMANN</b>				22d. ADDRESS <b>413 EASTERN AVE, BALTIMORE 21, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Tickenorson Balto 17 Md</b>				25a. REC'D BY REGISTRAR <b>29 61</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Tickenorson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8913

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

089986

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY in 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 30, Reisterstown</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institutional Residence, give admission) e. STATE <b>Puerto Rico</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  d. STREET ADDRESS <b>Box 546 Ciales</b> <span style="float: right;">87X-3</span> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>PABLO</b> Middle <b>ANTONIO</b> Last <b>SANTIAGO-ANDUGAR</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>20</b> , Year <b>19 61</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Puerto Rican</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 9. AGE (In years last birthday) <b>25</b> yrs. <span style="float: right;">IF UNDER 1 YEAR: Months Days Hours Min.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b>						<b>14. MOTHER'S MAIDEN NAME</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b>		Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of base of skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of auto which overturned and deceased was thrown from car</b>									
<b>20c. TIME OF INJURY</b> Hour <b>10:15</b> p.m.		Month, Day, Year <b>8/20/ 19 61</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Route 30</b>		<b>20f. (City or town)</b> <b>Reisterstown, Baltimore, Md.</b>		(County) _____ (State) _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input type="checkbox"/>. and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> 						<b>CHIEF MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>EXAMINER'S NAME</b> (Type) <b>Russell S. Fisher, M.D.</b>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DATE SIGNED</b> <b>8/21/61</b>						Address (Street, city, town, or county)							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)				<b>22b. DATE THEREOF</b> <b>9.6.61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>V. of Md. Med. School</b>				<b>22d. LOCATION</b> (City, town, or country) (State) <b>Baltimore, Md.</b>			
<b>23. FUNERAL DIRECTOR</b> <b>from City Morgue</b>						<b>24a. REC'D BY REGISTRAR</b> <b>DAEP 8 '61</b>						<b>24b. REGISTRAR'S SIGNATURE</b> 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8914  
CERTIFICATE OF DEATH

08905

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>581 Welbrook Road</b>		d. STREET ADDRESS <b>581 Welbrook Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernard J. Schepers Sr.</b>		4. DATE OF DEATH <b>August 26 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1884</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Airplane Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Schepers</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-23-2207</b>	
17. INFORMANT <b>Bernard Schepers Jr.</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>177X</b> IMMEDIATE CAUSE (a) <b>Uremic Coma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostatic carcinoma, metastatic</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerotic dis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 or 3 days</b> <b>1 yr.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/20 1961</b> to <b>8/26 1961</b> , that (I) (we) last saw the deceased alive on <b>8/25 1961</b> , and that death occurred at <b>11 A-M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Blatt</b>		22b. DATE SIGNED <b>8/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. BLATT, M.D.</b>		22d. ADDRESS <b>434 Eastern Ave. East end</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/29/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Bruzdziński</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>		25c. ADDRESS <b>1407 Eastern Ave.</b>	

# CERTIFICATE OF DEATH

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Belmont

Box (2)

Box (2)

221 Belmont Road

221 Belmont Road

Belmont, J. Belmont St.

Box (2)

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Box (2)

Belmont, J.

Belmont, J.

Belmont, J.

John Belmont

John Belmont

221 Belmont Road

221 Belmont Road

Belmont, J.

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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, adding the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08906

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Carriston</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Balto. 7</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Foxleigh Nursing Home</i>				d. STREET ADDRESS <i>6649 Dalton Drive</i>			
3. NAME OF DECEASED (Type or print) <i>FANNIE</i>		First Middle Last <i>SCHIFF</i>		4. DATE OF DEATH <i>Aug 31 1961</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 30, 1901</i>	9. AGE (In years last birth day) <i>60</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Late Benjamin Koppel</i>				14. MOTHER'S MAIDEN NAME <i>Late Hinda ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-34-1050</i>		17. INFORMANT <i>Foxleigh Nursing Home Records Howard R. Schiff, 4749 Belle Fort Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <i>none</i>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>none</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i>none</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D.D. Caples</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>D. D. CAPLES, M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>9/1/61</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Beth Tfeloh Cong.</i>				22d. LOCATION (City, town, or country) (State) <i>Baltimore, Md.</i>			
23. FUNERAL DIRECTOR <i>Sol Lewenson &amp; Bros., 6010 Reist. Rd., Balto 15</i>				24a. REC'D BY REGISTRAR <i>SEP 5 '61</i>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thane</i>			

MEDICAL CERTIFICATION

2

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1901 00



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, completely fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before death) a. STATE <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>146 Oak Avenue</u>				d. STREET ADDRESS <u>146 Oak Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Lou.</u> Middle <u>V.</u> Last <u>Scott</u>		8. DATE OF BIRTH <u>8-20-1881</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female Colored</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>William Perrin</u>		14. MOTHER'S MAIDEN NAME <u>Ella Allen</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Prince Edward Co., Va.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Lea V. Jeffers 1218 N. Spring St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u> DUE TO (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>AGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>JAN</u> , 19 <u>61</u> to <u>June</u> , 19 <u>61</u> ; that (I) ( <u>we</u> ) saw the deceased alive on <u>June</u> , 19 <u>61</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>JM Jones Jr MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JM Jones Jr MD</u>		22d. ADDRESS <u>1640 CAROLINE ST</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>8-15-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Farmville, Va.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph Rodlick</u>		ADDRESS <u>1412 E. Preston St.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 16 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneel</u>			

(M)

(1)

*John Jones*

AND 18 91

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8917

## CERTIFICATE OF DEATH

Reg. Dist. No. 08947

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>		d. STREET ADDRESS <b>4614 Reisterstown Road</b>	
3. NAME OF DECEASED (Type or print) <b>Arthur W. H. Schultz</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1874</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> Span. Amer.	
16. SOCIAL SECURITY NO. <b>219-01-0663</b>		17. INFORMANT <b>Mrs. M.V. Bright</b> Address <b>4614 Reisterstown Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>467.2</b> <b>Arteriosclerotic Crigane of heart by</b> DUE TO <b>Vascular Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 18, 1961</b> , to <b>Aug 22, 1961</b> , that I last saw the deceased alive on <b>Aug 22, 1961</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Cliff Ratliff</b> M.D.		ADDRESS (Street, city or town, state) <b>4605 Edmonds Ave</b> DATE SIGNED <b>8/23/61</b>	
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>		<b>Baltimore 29, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-25-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. Vernon Lemmon</b>		ADDRESS <b>4611 Park Heights Ave.,</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

8918

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08909

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Arbutus)</b>				c. LENGTH OF STAY IN 1b <b>X Baltimore (Arbutus)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5552 Carville Avenue</b>				d. STREET ADDRESS <b>5552 Carville Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helena</b>		First <b>D.</b> Middle <b>SXX</b> Last <b>Sewell</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9,</b> Year <b>1961</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 4, 1872</b>	
9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nursing</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Heiner</b>				14. MOTHER'S MAIDEN NAME <b>Fredericka Marrs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Marguerite Huber 5552 Carville Avenue #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parasomnia liver -</b> 156.1 DUE TO <b>Pecheuxia - bologan die -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Sabuloneus Rappenburg</b> (b) DUE TO <b></b> (c) DUE TO <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>1 month +</b> <b>10 yrs</b>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1961</b> to <b>Aug 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 9, 1961</b> , and that death occurred on <b>Aug 9, 1961</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Frederic V. Beitler</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>Frederic Beitler, M. D.</b> 22d. ADDRESS <b>Francis Avenue, Halethorpe 27, Md.</b> 22b. DATE SIGNED <b></b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard 4107 Wilkens Avenue Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8919

08910

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essey</i>		c. LENGTH OF STAY IN 1b <i>X Essey</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1020 Mace Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN EDWARD SHANAHAN</i> First Middle Last		4. DATE OF DEATH <i>Aug. 7TH 1961</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-15-1908</i> Yrs. <i>52</i>
9. AGE (In years last birthday) <i>52</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Shanahan</i>	
14. MOTHER'S MAIDEN NAME <i>Miller</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>214-01-5088</i>		17. INFORMANT <i>Joe. F. Shanahan (same as above)</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Failure</i> DUE TO (b) <i>Cancer of the lung with extensive metastases</i> DUE TO (c) <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>11/6 60 8/7 1961</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>11/6 60 8/7 1961</i> , that (I) (we) last saw the deceased alive on <i>8/3 1961</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.	
22a. SIGNATURE <i>Eugene C. Baumann</i> M.D.		22b. DATE SIGNED <i>8/9/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>EUGENE C. BAUMANN</i>		22d. ADDRESS <i>413 EASTERN AVE, BALTIMORE 21, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>8-11-1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Zion Lutheran Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Connolly</i> ADDRESS <i>418 Eastern Blvd. 21 Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 11 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1912

1912

*[Faint, mostly illegible handwritten text, likely a death certificate form. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and correctly filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8920

CERTIFICATE OF DEATH

Reg. Dist. No.

08911

1. PLACE OF DEATH o. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>				c. LENGTH OF STAY IN 1b <b>6 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>62 BROADSHIP RD</b>				d. STREET ADDRESS <b>62 BROADSHIP</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAWRENCE LEO SHEARER</b>				4. DATE OF DEATH Month Day Year <b>AUG. 21 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 3, 1882</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME CONSTR.</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WM. SHEARER</b>				14. MOTHER'S MAIDEN NAME <b>MARY A. KRAUS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>26-16-9383</b>		17. INFORMANT <b>MRS. WM. J. LONG</b>		Address <b>AS #2 ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 10 YRS <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1955</b> , to <b>21 AUG. 1961</b> , that I last saw the deceased alive on <b>27 MARCH 1961</b> , and that death occurred at <b>2:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1105 OLD EASTERN AVE. ESSEX 21, MD.</b> DATE SIGNED <b>8-21-61</b>							
ACTUAL SIGNATURE <b>Morris Rainess</b>				PHYSICIAN'S NAME (Type) <b>MORRIS RAINESS, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/24/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. BONIFACE CHURCHYARD</b>		22d. LOCATION (City, town, or county) (State) <b>LEADING CREEK - W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Bradley - 700 Hollow Spring Dundalk, Md.</b>				24a. DEED BY REGISTRAR <b>Aug 22 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

5570

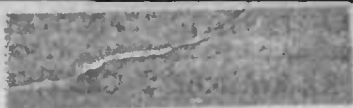
*[Faint handwritten notes at the bottom of the page]*



12  
FOR STATE  
HEALTH DEPT. (M)  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8921 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08912

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY in lb <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6805 ROBERTS AVE.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> d. STREET ADDRESS <u>6805 Roberts Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>ANDREW W. SMINK</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/10/1912 (12)</u>		9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u>		11. IF UNDER 24 HRS. Hours <u>13</u> Min. <u>1961</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BETH. STEEL</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PENNSYLVANIA</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>SMINK</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>204-094868</u>				17. INFORMANT <u>ELEANOR</u> Address <u>6805 Roberts Ave</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>420.</u> (c) <u>1</u> DUE TO												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>M.B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8/14/61</u>							
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>				Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>8-17-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>				22d. LOCATION (City, town, or country) (State) <u>BALTIMORE MARYLAND</u>			
23. FUNERAL DIRECTOR <u>Stalter</u>				24a. REC'D BY REGISTRAR <u>1661</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kump</u>				24c. ADDRESS <u>1005 Dundalk Ave.</u>											



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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08913

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton</b>		c. LENGTH OF STAY IN life <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton</b>		d. STREET ADDRESS <b>Shepperd Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shepperd Road</b>				a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joe Morrison Sparks</b>				4. DATE OF DEATH <b>Aug. 2 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1877 83</b> yrs.		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis Morrison Sparks</b>				14. MOTHER'S MAIDEN NAME <b>Julia Remare</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-38-6504</b>		17. INFORMANT <b>Pauline P. Sparks</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Arterio sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1 1961</b> , to <b>Aug. 2 1961</b> that (I) (we) last saw the deceased alive on <b>Aug. 1 1961</b> , and that death occurred at <b>5 a.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. M. France</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. M. France</b>				22d. ADDRESS <b>Parkton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns (Long Green)</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore County Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>				25a. REC'D BY REGISTRAR <b>4905 York Rd., 12</b>		25b. REGISTRAR'S SIGNATURE <b>AUG 4 '61</b>	

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Johnson

Wife

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Shannon, Fred

Shannon, Fred

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Oct. 18, 1939

Franking

Franking

Franklin, Norman Sparks

Franklin, Norman Sparks

no

215-15-0100 is same as report

Cardinal Thompson

Investigation

Radio Reports

10-11-39

10-11-39

Franklin, N.

Franklin, N.

10-11-39

St. John (Long Street) Baltimore

St. John (Long Street) Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8923

CERTIFICATE OF DEATH

08914

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			
c. LENGTH OF STAY in lb <u>Life</u>				d. STREET ADDRESS <u>Shepperd Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shepperd Road</u>				a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Pauline</u> First <u>P.</u> Middle <u>S.</u> Last <u>SPARKS</u>				<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-29-1871</u>	
9. AGE (in years) <u>90</u> yrs.		10. UNDER 1 YEAR Months <u>9</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Brooke Pleasants</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jenkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Helen Troy Hayden</u> Address <u>Washington, D.C.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinomatosis</u> DUE TO (b) <u>199x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>199x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1961</u> to <u>Aug 8, 1961</u> that (I) (we) last saw the deceased alive on <u>Aug 8, 1961</u> and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. M. France</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				22d. ADDRESS <u>PARKTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Co. (Hyde P.O.) Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins &amp; Sons CO.</u> ADDRESS <u>4905 York Rd. Balt</u>				25a. REC'D BY REGISTRAR <u>Aug 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>	

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Handwritten notes and signatures, including "C. M. F. Finance" and "H. M. Finance".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
8924 08915											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>					
c. LENGTH OF STAY IN 1b <b>21 Days</b>						d. STREET ADDRESS <b>55 DOUGLAS STREET</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>SAMUEL</b> <b>STAFFORD</b>						4. DATE OF DEATH Month <b>AUGUST</b> Day <b>26</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 17, 1895</b>		9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oyster Shucker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster Company</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Martin L. Stafford</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Stiles</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW I 217-10-8667</b>				17. INFORMANT <b>Clin. Records, VAH, Balto. Md. Ft. Howard Division</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG WITH METASTASIS TO BRAIN</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>August 5</b> , 19 <b>61</b> to <b>August 26</b> , 19 <b>61</b> , that <del>he</del> (we) last saw the deceased alive on <b>August 26</b> , 19 <b>61</b> , and that death occurred <b>3:15AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>M. Lawrence Rubin, M.D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>8/27/61</b> 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>M. LAWRENCE RUBIN, M.D.</b>						22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIV.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8-31-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson Funeral Home, 1000 Brantley Ave. Baltimore, Md.</b>						25a. REC'D BY REGISTRAR <b>AUG 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8925

## CERTIFICATE OF DEATH

08916

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTO.</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b> c. LENGTH OF STAY IN 1b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GRAND-DAUGHTER'S HOME</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> <span style="float: right;">b. COUNTY <b>✓</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b> d. STREET ADDRESS <b>334 S. ROBINSON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>ANNA MAY STICHEL</b>				<b>4. DATE OF DEATH</b> Month <b>AUG.</b> Day <b>2</b> Year <b>1961</b>					
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>AUG. 26, 1890</b>		<b>9. AGE</b> (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>TICKET MGR. THEATER</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MD.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>THOMAS SIMS</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>NOT KNOWN</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-22-3838</b>		<b>17. INFORMANT</b> Address <b>CHARLES STICHEL 334 S. ROBINSON</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHO SARCOMA OF RT. INGUINAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>200.1</b> (b) <b>WITH METASTASIS TO SPLEEN LUNG</b> (c) <b>AND BRAIN</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4-10-61</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>EXCISION OF MASS AT S.B.G.H. 7-21-61.</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>NONE</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> While not at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.) <b>NONE</b>		<b>20f. (City or town)</b> <b>NONE</b>		(County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <b>4-10-61</b> to <b>8-2-61</b>, that (I) (we) last saw the deceased alive on <b>8-2-61</b>, and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>E. A. Schimmuck</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>F. A. SCHIMMUCK M.D.</b>				<b>22d. ADDRESS</b> <b>842 S. EAST AVE BALTO. 24 MD.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>AUG. 5, '61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>oak lawn</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>BALTO. CO. MD.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>S. V. Hoffmann</b>				<b>ADDRESS</b> <b>3218 HUDSON ST.</b>		<b>25a. REC'D BY REGISTRAR</b> DATE <b>AUG 4 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Krens</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08917

8926

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5232 Arbutus Avenue</b>				d. STREET ADDRESS <b>5232 Arbutus Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Stier, Sr.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> , Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1875</b>		9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B &amp; O R. R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Foreman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Stier</b>				14. MOTHER'S MAIDEN NAME <b>Mary F. Jamart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Bertha W. Stier 5232 Arbutus Avenue #XX #27</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Generalized arteriosclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>Aug 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 31, 1961</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Stanley Ankudas</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Stanley Ankudas, M. D.</b>				22d. ADDRESS <b>1802 W. Baltimore Street</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Avenue #29</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 25 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
VR A15 (4)  
15M 9/59

34

1





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8795

Item 24 Film G295 9/14/61 ink Items 23-9/18/61

118918

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1624 Light Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>John</b> Last <b>Stokes</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1903</b> 9. AGE (in years last birthday) <b>58</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Stokes</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Lettau</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Natl. Guard 110th fld. art. -Pikesvll.</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia - entire right lung</b> 493 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Heart failure</b> (c) <b>atrial fibrillation &amp; myocardial damage</b> long standing INTERVAL BETWEEN ONSET AND DEATH <b>few days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>cellulitis - left leg</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>Aug. 19</b> , 1961 to <b>Aug. 24</b> , 1961, that (I) (we) last saw the deceased alive on <b>Aug. 24</b> , 1961, and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b> M.D.		22b. DATE SIGNED <b>8-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>Aug. 31, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Flynn &amp; Fleming</b>		25a. RECEIVED BY REGISTRAR <b>Aug 29 '61</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

81-101

2013

M

Section 100-100

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8527  
CERTIFICATE OF DEATH  
08919

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>Mayfair Hotel, Mt. Royal &amp; Charles Sts.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT E. SWEETLAND</b>		First		Middle		Last		4. DATE OF DEATH <b>August 29 19 61</b>		Month		Day		Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>December 20, 1906</b>		9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Purchasing Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Clubs</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Henry Sweetland</b>		14. MOTHER'S MAIDEN NAME <b>Cora Hermert</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>547-07-9837</b>		17. INFORMANT <b>Clinical Records, VAH, 3900 Loch Raven Blvd. Baltimore 18, Md - FORT HOWARD DIVISION</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>THROMBOSIS OF RIGHT CORONARY ARTERY</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>ULCERATION OF OROPHARYNGEAL REGION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>		UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>		(State) <b>Md</b>	
21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>August 23, 1961</b> , to <b>August 29, 1961</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>August 29, 1961</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>SEBASTIAN RUSSO, M.D.</b>		22b. DATE <b>8/31/61</b>		22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-2-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore</b>		23d. LOCATION (City, town or county) <b>28, Maryland</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>											



RECORDS OF THE NATIONAL ARCHIVES

RECORDS OF THE NATIONAL ARCHIVES

2000-11-11

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8928

08920

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9yr4mth2dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre deGrace, Maryland</b>		d. STREET ADDRESS <b>716 Ontario Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1879</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>24</b> Hours <b>2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph McVey</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Tollinger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-40-7504</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 9, 1952</b> , to <b>8-11-61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-11-1961</b> , and that death occurred <b>11:00 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jose R. Arizaga</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>AUG 15 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WEST NOTTINGHAM CEM.</b>		23d. LOCATION (City, town or county) <b>CECIL, CO.</b>		(State) <b>MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>				ADDRESS <b>Havre de Grace MD</b>		25a. REC'D BY REGISTRAR <b>AUG 16 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Khand</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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CARTON/SCALES COLLATE

WATER TENSIVE VECTIC/SCALES COLLATE  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8929  
CERTIFICATE OF DEATH  
08921

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>				c. LENGTH OF STAY IN 1b <b>35 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>661 Oella Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>G.</b> Last <b>Tipton</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>2,</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1884</b>		9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Canapp</b>				14. MOTHER'S MAIDEN NAME <b>Mary Josephine Garrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-6077</b>		17. INFORMANT Address <b>Mrs. Edwin Fisher 661 Oella Ave. Oella, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vasc. Disease</b> DUE TO (c) <b>3 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 4, 1956</b> to <b>Aug 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 1, 1961</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William F. Cassaway</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug 2, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>William F. Cassaway M. D.</b>				22d. ADDRESS <b>Ellicott City, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/5/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b> ADDRESS <b>Catonsville, Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, it should be executed within 72 hours after death. The body should be placed in a coffin or other suitable container and the certificate, with the word "pending" in pencil in item 18, should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08922

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>				c. LENGTH OF STAY IN 1b <b>35 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>510 D Street</b>				e. STREET ADDRESS <b>510 D Street</b>			
3. NAME OF DECEASED (Type or print) First <b>ELTA</b> Middle <b>MINNIE</b> Last <b>TOWSON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9th</b> Year <b>19 61</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1905</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Walter Stevenson</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Green</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Robert Barry</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation by putting</b> <b>9774X</b> DUE TO <b>PLASTIC bag over head</b> Conditions, if any, which gave rise to immediate cause (b) <b>PLASTIC bag over head</b> cause last. (c) <b>PLASTIC bag over head</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Placed plastic bag over head</b>					
20c. TIME OF INJURY Month <b>Not known</b> Day <b>Not known</b> Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, institution, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Sparrows Point Baltimore Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b>		EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/10/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk 22, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thompson</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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8931

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08923

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1243 Francis Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Isabel V. Tubbs</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> , Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/77</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1243 Francis Ave.</b>	
17. INFORMANT <b>Roland F. Tubbs</b>		Address <b>1243 Francis Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Chronic renal insufficiency</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>2 years</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1959</b> to <b>August 1961</b> , that (I) (we) last saw the deceased alive on <b>July 12, 1961</b> , and that death occurred at <b>7:11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>R. J. Donovan</b>		22b. DATE SIGNED <b>August 6, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. J. Donovan M.D.</b>		22d. ADDRESS <b>732 Charing Cross Rd. (29)</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Anna, Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Sp. Rd.</b>		25. REC'D BY REGISTRAR DATE <b>AUG 8 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

# CERTIFICATE OF DEATH

1933

(M)

Name of Deceased: *John J. Smith*  
 Date of Death: *1933*  
 Place of Death: *185 Franklin Ave.*  
 Cause of Death: *Heart Disease*  
 Age: *45*  
 Sex: *Male*  
 Marital Status: *Married*  
 Occupation: *Unknown*  
 Signature of Physician: *John J. Smith*  
 Signature of Registrar: *John J. Smith*  
 Date of Registration: *1933*  
 Place of Registration: *185 Franklin Ave.*

This is to certify that the above is a true and correct copy of the original record of death as filed in the office of the Registrar of Deaths for the City and County of New York.  
 Registrar of Deaths  
 City and County of New York



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8932

08924

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>227 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>608 BURGUNDY STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR E. TWYMAN</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 26 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Market</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Bolivar, West Virginia</b>
13. FATHER'S NAME <b>John Twyman</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Anderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>236-03-1008</b>	
17. INFORMANT <b>Clin Records, VAH, Baltimore, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE HEMORRHAGE FROM GI TRACT</b> DUE TO <b>ESOPHAGEAL VARICES</b> Conditions any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>FATTY LIVER WITH CIRRHOSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY CONGESTION.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>1 1/2 YEARS</b> <b>1 1/2 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 10, 1961</b> to <b>August 26, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 26, 1961</b> and that death occurred at <b>12:00N</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>M. Lawrence Rubin</b>		22b. DATE SIGNED <b>8/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. LAWRENCE RUBIN, M.D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIV.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-31-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City, town or county) (State) <b>BALTIMORE 28, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson</b>		25a. REC'D BY REGISTRAR <b>AUG 30 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

Elroy O. Wilson Funeral Home, 1000 Brantley Ave.  
Balto. Md.

M

Miss J. Wilson (Lateral Bone), 1000 Franklin Ave.,  
Chicago, Ill.

1000 Franklin Ave.  
Chicago, Ill.

1000 Franklin Ave., Chicago, Ill.

Chicago, Ill.

1000

1000 Franklin Ave., Chicago, Ill.

1000 Franklin Ave., Chicago, Ill.

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1000 Franklin Ave., Chicago, Ill.

1000 Franklin Ave., Chicago, Ill.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08925											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21 (Essex)</b>						c. LENGTH OF STAY IN 1b <b>Baltimore (Essex) 21</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>581 Edgewater Apartments</b>						d. STREET ADDRESS <b>581 Edgewater Apartments</b>					
3. NAME OF DECEASED (Type or print) <b>NORWOOD T. UNDERWOOD</b>						4. DATE OF DEATH Month <b>Aug.</b> Day <b>24</b> Year <b>61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 2, 1926</b>		9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>34</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>				11. BIRTHPLACE (State or foreign country) <b>N. C.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John L. Underwood</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Sykes</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW1</b>				16. SOCIAL SECURITY NO. <b>246-24-7644</b>		17. INFORMANT <b>Ellen Underwood</b>		Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute alcohol and paraldehyde intoxication</b> <b>888.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested paraldehyde in addition to alcohol.</b>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>unknown 8/24 1961</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Baltimore 21</b>		(County) <b>Balto.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Russell S. Fisher</b>						M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>8/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge Memorial Pk.</b>		22d. LOCATION (City, town, or country) (State) <b>A. A. County, Maryland</b>	
23. FUNERAL DIRECTOR <b>James E. Bruzdinski 1407 Eastern Ave.</b>						24a. REC'D BY REGISTRAR <b>AUG 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			

MEDICAL CERTIFICATION

NOV 1945

(1)

James A. Hirschfeld 1107 Eastern Ave.  
Bureau  
61661  
New York National Ex. A. A. Comm., Inc.

Yes Will John L. Underwood  
206-24-64 Ellen Underwood Same  
Lillian Sykes

Abraham Steel H. C.

John H. Underwood Dec. 2, 1935

John L. Underwood

John L. Underwood

NOV 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

8934

08926

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 27</b> d. STREET ADDRESS <b>4427 Allen Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House In The Pines, 16 Fusting Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Jeanette Valentine</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>18,</b> Year <b>19 61</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>10</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13. FATHER'S NAME <b>John Peel</b>	14. MOTHER'S MAIDEN NAME <b>Anne---</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Niece) <b>Mrs. Lawrence W. Pruitt,</b> Address <b>1934 Old Frederick Rd</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cordis-Vascular Disease</b> causing the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 pm.?</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from **8-18-61**, to **8-18-61**, that (I) ~~(we)~~ last saw the deceased alive on **8-18-61**, and that death occurred at **6:30 PM**, from the causes and on the date stated above.

22a. SIGNATURE <b>Wilmer K. Gallager</b>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>8-19-61</b>
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallager M.D.</b>		22d. ADDRESS <b>6209 Frederick Ave. Balt. 28 Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 21, 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk.</b>	23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>
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24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F.D. 4101 Edmondson Ave</b>	25a. REC'D BY REGISTRAR <b>AUG 21 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

Baltimore

Baltimore

House in the line, 15 Westing Ave. East, Baltimore

January

Washington

April 2, 1965

Our name

John Ford

T

(1965)

John Ford, 1965

John Ford, 1965

John Ford, 1965



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8935

## CERTIFICATE OF DEATH

08927

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY in 1b <b>2 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b> d. STREET ADDRESS <b>427 South Macon Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE S. VARIPATIS</b>		4. DATE OF DEATH Month Day Year <b>August 29 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 15, 1915</b> 9. AGE (In years last birthday) <b>45</b> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Weirton W. Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Estratius J. Varipatis</b>	
14. MOTHER'S MAIDEN NAME <b>Irene De Foni</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>213-07-3066</b>		17. INFORMANT Address <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RIGHT BRONCHUS WITH METASTASIS TO LEFT LOWER LOBE</b> Conditions, if any, which gave rise to immediate cause (b) <b>SEVERE CHRONIC NEPHROSCLEROSIS</b> (c) <b>MYOCARDIAL HYPERTROPHY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>August 27, 1961</b> , to <b>August 29, 1961</b> , that (X) (we) last saw the deceased alive on <b>August 29, 1961</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Sebastian Russo</b> NAME (Type) <b>SEBASTIAN RUSSO, M. D.</b>		22b. DATE SIGNED <b>8/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>SEBASTIAN RUSSO, M. D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-2-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greek Orthodox Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore County, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Matthews Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

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TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

101

1

Deborah

John Howard

2 days

Bellevue St

147 South Main Street

Veterans Administration Hospital

Deborah

Valentine

August

White

November 12, 1915

Patsey

Constitution

Walter W. Virginia

U. S. A.

Washington D. Virginia

James De Ford

Clinton, Howard, VAH, Baltimore 18, Maryland  
TOM HOWARD DIVISION

213-C-5000

WM II

Yes

BROWNSVILLE, TEXAS, BROWNSVILLE

BOOK MEMBERS TO THE 10TH DATE

SEVEN CHARGE MEMBERSHIP

BOOK

MEMORIAL HISTORY

MEMORIAL

UNITED

MEMORIAL

*Handwritten signature*

CHRISTIAN WESS, M. I.

VAH, BALTIMORE 18, MD., BROWNSVILLE DIVISION

EM-1

2-5-61

Green Oakwood Cemetery

Baltimore County, Maryland

Matthews Funeral Home

3000, Newcomb Ave. Baltimore

SEP 2, 1961

CHAS. L. WESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8936					CERTIFICATE OF DEATH					08928	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b>					c. LENGTH OF STAY IN Ib					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>609 Murdock Road, Zone 12</b>					d. STREET ADDRESS <b>609 Murdock Rd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN H. VOLZ</b>					4. DATE OF DEATH <b>August 2 19 61</b>						
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/18/1881</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph A. Volz</b>					14. MOTHER'S MAIDEN NAME <b>Sophia Hodes</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>213-05-1055</b>		17. INFORMANT <b>Sophia Volz, daughter, above</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardio-vascular Disease</b> <b>422.1</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema, Severe</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 yts.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 1959</b> to <b>Aug 1961</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>July 25 1961</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Wm H Kammer 2.</b>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3 Aug. 1961</b>		
22c. PHYSICIAN'S NAME (Type) <b>Wm H. Kammer, Jr.</b>					22d. ADDRESS <b>6011 York Rd. Balto. 12, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>			23d. LOCATION (City, town or county) <b>Baltimore, Md.</b>			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek Funeral Home</b> <b>3331 Brehms Lane</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>AUG 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8937

## CERTIFICATE OF DEATH

08929

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1913 LISMORE RANE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> <span style="float: right;">b. COUNTY <u>BALTO.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>1913 LISMORE RANE</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>MILTON PARKER VORE</u>				<b>4. DATE OF DEATH</b> Month <u>AUG.</u> Day <u>24</u> Year <u>1961</u>									
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>OCT. 7, 1914</u>		<b>9. AGE</b> (In years, leg. birthday) <u>46</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ELEC. CO.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CALIFORNIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>MILTON P. VORE, JR.</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>JOSEPHINE WOOD</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> Address <u>Mrs. Milton P. Vore - 1913 Lismore Lane</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 204.3 DUE TO <u>Acute myelogenous leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>8 mo +</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>								<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>8/12/61</u> to <u>8/24/61</u> , that (I) (we) last saw the deceased alive on <u>8/24/61</u> , and that death occurred at <u>8P</u> M., from the causes and on the date stated above.								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>22a. SIGNATURE</b> <u>James E. Rowe</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>8/25/61</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>  </u>				<b>22d. ADDRESS</b> <u>  </u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8-28-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Londal Park Cem</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Balto Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Stacy - Conway &amp; F.H. Catonsville, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>SEP 1 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hanna</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8938

## CERTIFICATE OF DEATH

Item 7 Film 9292 8/15/61

08938

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY in 1b <b>25yr7mth6dys</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Woodsboro, Maryland</b> d. STREET ADDRESS <b>10x2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles H. Weinbrenner</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>7</b> Year <b>1961</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plumber</b>		9. AGE (In years last birthday) <b>84</b> yrs.		10. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		12. DATE OF BIRTH <b>Sept. 8, 1876</b>	
13. FATHER'S NAME <b>Thomas Jefferson Weinbrenner</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral and Generalized arteriosclerosis</b> (c) <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>332X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from <b>Dec. 25, 1935</b> to <b>Aug. 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 7, 1961</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Stella Wachslar</b> M.D.		22b. DATE SIGNED <b>8-8-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>8/10/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>not Hope</b>		23d. LOCATION (City, town or county) (State) <b>Woodsboro</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>W.C. Barton</b>		25a. REC'D BY REGISTRAR <b>Aug 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>		25e. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>		25f. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08932

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MTCARMEL &amp; EUNA RDS.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u> d. STREET ADDRESS <u>1 MT. CARMEL &amp; EUNA RDS.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>FLORENCE VALIANT WEST</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>AUGUST 13 19 61</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JAN. 19, 1879</u>
<b>9. AGE</b> (In years last birthday) <u>82</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days	<b>11. IF UNDER 24 HRS.</b> Hours Min.
<b>12a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>12b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u>	
<b>13. FATHER'S NAME</b> <u>HERB JOSEPH G. VALIANT</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZA ANN OLIVER</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio - Sclerotic Cardio Vascular disease</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from <u>8-13</u>, 19<u>61</u> to <u>8-13</u>, 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>8-13</u>, 19<u>61</u>, and that death occurred at <u>2 P.M.</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>C. Herbert Mueller Jr</u> M.D.		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>C. HERBERT MUELLER JR</u>		<b>22d. ADDRESS</b> <u>PARKTON, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>8-15-61</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GREEN MOUNT</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>BALTIMORE, MD.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>JOHN O. MITCHELL &amp; SONS, INC.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Aug 16 61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knepp</u>	

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2-1-1908

Parkton

Mittemel + Emma Rod

Female

White

X

West

Jan 19, 1877 82

Home

Housewife

Joseph C. Variat

Ella Ann Cook

Maryland

Order of the Court  
to the Clerk of the Court

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C. Herbert Hester Jr

C. Herbert Hester Jr

Parkton, MD

Born 8-12-11 Green Mount

Baltimore, MD

John C. Mitchell & Son, Inc. Inspection Place

West of City 2 mi

Maryland Baltimore

Parkton

Mittemel + Emma Rod

Female

White

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Jan 19, 1877 82

Maryland

Ella Ann Cook

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 08953

8941

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3716 Mohawk Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>B.</b> Last <b>West</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl August Boucsein</b>		14. MOTHER'S MAIDEN NAME <b>Louise Caroline Bersch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-34-0100</b>	
17. INFORMANT <b>Joan W. Gundlach-2411 Poplar Dr. #7</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>*****</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>*****</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>*****</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <b>*****</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>*****</b>		20f. (City or town) (County) (State) <b>*****</b>	
21. I certify that I attended the deceased from 19 <b>55</b> , to <b>August 61</b> , that I last saw the deceased alive on <b>August 21</b> , 19 <b>61</b> , and that death occurred at <b>3:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5101 Gwynn Oak Ave.</b> DATE SIGNED <b>8/22/61</b> ACTUAL SIGNATURE <b>Millard T. Traband, Jr.</b> M.D. <b>Baltimore, 7, Md.</b> PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/25/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost 4600 Liberty Heights Ave.</b>		24a. REC'D BY REGISTRAR <b>AUG 22 '61</b> DATE <b>Ellsworth Armacost</b>	
24b. REGISTRAR'S SIGNATURE <b>Ellsworth Armacost</b>		24c. REGISTRAR'S SIGNATURE <b>Ellsworth Armacost</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8942 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 08934

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dunmanway Extended</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>PERRY ALBERT WILBURN, Jr.</b>		4. DATE OF DEATH Month Day Year <b>August 3rd, 1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1942</b>
9. AGE (In years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Perry A. Wilburn, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Ida Oehring</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-40-2189</b>	
17. INFORMANT <b>P. A. Wilburn, Sr., same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Convulsion</b> DUE TO (c) <b>Epilepsy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1</b> , 19 <b>55</b> , to <b>8-3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>7-10</b> , 19 <b>61</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Jack Collins</b> M.D. <b>Z. Kinsky</b> <b>8-3-61</b> PHYSICIAN'S NAME (Type) <b>JACK C Collins</b> <b>Baltimore 22 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/5/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled by the attending physician and completed by the funeral director. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08935

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>62 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>127 Longview Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Henry</b> Last <b>Willingham</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1888</b>
9. AGE (In years lost birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bridge carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Willingham</b>		14. MOTHER'S MAIDEN NAME <b>Mary Owings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-3043</b>	
17. INFORMANT <b>Mrs. Maggie Willingham</b>		Address <b>Catonsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery disease</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Cerebral Vascular Disease</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 4, 1953</b> to <b>Aug 21, 1961</b> , that (I) (we) lost the deceased alive on <b>August 16, 1961</b> , and that death occurred at <b>4:30 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>J. Nelson McKay</b>		22b. DATE SIGNED <b>Aug 22, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. NELSON MCKAY</b>		22d. ADDRESS <b>6014 EDMONDSON AVE CATONS. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/24/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		23d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 23 '61</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, the day should be noted in the space provided. The certificate should be executed by the medical director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. If any day is necessary, the day should be noted in the space provided. The certificate should be executed by the medical director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8944 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08936

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - COCKEYSVILLE</b> c. LENGTH OF STAY IN 1b <b>HARRISBURG EXPRESSWAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD</b> f. COUNTY <b>—</b> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b> h. STREET ADDRESS <b>5316 THE ALAMEDA</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILMER JEANNE WOLF</b>			4. DATE OF DEATH Month <b>AUG.</b> Day <b>5</b> Year <b>1961</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-13</b>		9. AGE (In years last birthday) <b>48</b> IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> IF UNDER 24 HRS.: Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLAIMS ADJUSTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>WARREN A. WOLF</b>		
14. MOTHER'S MAIDEN NAME <b>LOLA ARNOLD</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WWII</b>		
16. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT <b>RITA I. WOLF</b> Address <b>ABOVE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 MIN.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>—</b> p.m. <b>—</b> Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>William A. Pinsbury</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-5-61</b>	
EXAMINER'S NAME (Type) <b>William A. Pinsbury</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-9-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GRANDVIEW</b>	22d. LOCATION (City, town, or country) (State) <b>ALLEN TOWN PA.</b>		
23. FUNERAL DIRECTOR <b>H.W. JENKINS &amp; SONS Co. 4905 YORK RD. BALTO. 12</b>			24a. REC'D BY REGISTRAR <b>—</b> 24b. REGISTRAR'S SIGNATURE <b>—</b>		

MEDICAL CERTIFICATION

(M)

(1)

WACCO A. WOLF

WOLF

PENNA

LOW JENNY

WOLF

ACCOE

CLINTON AUGUST 11.2.1947

U.S.A.

ATTENTION

Box 10-1 of 1000000

H.W. Jenkins & Sons 12 1/2 Ave York Pa 17403



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08957

8945

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1703 REISTERSTOWN RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MAE</u> Last <u>YOUNG</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 2, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISPATCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HUMANES SOCIETY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MEASLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218A-32-9887</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism - Pulmonary</u> DUE TO <u>Dissected Atherosclerotic Old Hypertensive - 1st Left Ventricle</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Failure</u> (c) <u>Chronic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 year</u>			
INTERVAL BETWEEN ONSET AND DEATH. <u>Instant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>August 30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>August 28</u> , 19 <u>61</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McElisimo</u>		ADDRESS (Street, city or town, state) <u>M.D. 11904 Reisterstown Rd, Reisterstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Clarence E. McElisimo</u>		DATE SIGNED <u>Aug 30, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SATER'S BAPTIST CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>LUTHERVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns</u>		ADDRESS <u>Somer, Towson, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

LOCATION: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Registrar's Signature: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_

Additional fields for medical history and circumstances of death.

RECEIVED  
JAN 10 1914  
DEPT. OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8946

Item 11, Film G293 8/24/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

08938

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1235 PRIMROSE AVE.</u>			d. STREET ADDRESS <u>11235 PRIMROSE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BARBARA</u> Last <u>ZARAS.</u>			4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
13. FATHER'S NAME <u>Anton Cernohorsky</u>			14. MOTHER'S MAIDEN NAME <u>Rosalie Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Anna R. West 1235 Primrose Ave. Balto.-6-Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1 Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic - Hypertensive C.V.D.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mastoid Carcinoma</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1961</u> to <u>Aug 18, 1961</u> , that I last saw the deceased alive on <u>Aug 18, 1961</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd., Baltimore, Maryland</u> DATE SIGNED <u>8/18/61</u>					
ACTUAL SIGNATURE <u>John G. Orth, M.D.</u>		DATE SIGNED <u>Aug 21 '61</u>			
PHYSICIAN'S NAME (Type) <u>John G. Orth, M.D.</u>		ADDRESS <u>8019 Philadelphia Rd., Baltimore, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 21, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bohemian National Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cwach</u>		ADDRESS <u>1211 Chesaco Ave. Balto.-6-Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased is in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

21  
8947  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08939

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>17 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 26</b> d. STREET ADDRESS <b>7819 Bridge Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAUL E. L. ZELLER</b>		4. DATE OF DEATH Month Day Year <b>August 30 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1894</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Munitions Inspector</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S. Govt. Ordinance Dept. Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George J. Zeller</b>		14. MOTHER'S MAIDEN NAME <b>Emily Scheckels</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Clinical Records, VAH, Baltimore 18, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA DUE TO ACUTE NEPHRITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5910X</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>August 13 1961, August 30 1961</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 13 1961</b> , to <b>August 30 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 30 1961</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>SEBASTIAN RUSSO, M.D.</b>		22b. DATE SIGNED <b>8/30/61</b>	
22c. PHYSICIAN'S NAME <b>SEBASTIAN RUSSO, M.D.</b>		22d. ADDRESS <b>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-2-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Anne Arundel County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully, 237 Patapsco Ave., Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

James I. McGowan, 221 Telephone Ave., Baltimore, Md.

Color Film Company

The American Company, Baltimore, Maryland

SEBASTIAN NURSE, M.D.

VAN, BALTIMORE 18, RD. 71, HOWARD DIVISION

August 30 1961

August 28 1961

*John McGowan*

Yes

Mr. I

George J. Kallor

Emily Schuchman

Insulation Inspector

Ordinance Dept. Baltimore, Maryland

U.S. Govt.

Male

July 24, 1961

PAUL A.

B.

WILLIAM

Mount

30

41

Veterans Administration Hospital

7000 Ridge Drive

Tort Howard

17 days

Baltimore

Maryland

Residence